CVS CAREMARK

Fax Referral To: 800-323-2445

Phone: 866-278-6634

Targretin® (bexarotene)
Enrollment Form
For Blue Cross Blue Shield of Rhode Island Members

Date: _____ **Needs by Date (Please Specify):** _____

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other:** _____

PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
SS #: _____
Insurance ID: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____
Contact Phone: _____

INSURANCE INFORMATION (*Please copy and attach the front and back of insurance and prescription drug card)*

Prescription Card: Name of Insurer: _____ ID#: _____ BIN: _____ PCN: _____ Group: _____
Primary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: **Blue Cross Blue Shield of RI** Phone: _____
Secondary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Diagnosis (ICD-9 Code): ☐ Other: _____ • Date of Diagnosis: _____

APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.

NOTE: Any areas that are not filled out will be considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

- Is the patient female of childbearing potential? ☐ Yes ☐ No ☐ N/A
  - If yes, did the patient have a confirmed negative pregnancy test? ☐ Yes ☐ No ☐ N/A
- Has the patient been instructed on the importance and proper utilization of contraceptive methods? ☐ Yes ☐ No
- Patient has a diagnosis of CTCL (includes mycosis fungoides [MF] and Sezary syndrome)? ☐ Yes ☐ No
  - If yes, please indicate CTCL stage: ☐ Stage IA ☐ Stage IB ☐ Stage IIA ☐ Stage IIB ☐ Stage III ☐ Stage IV ☐ Sezary Syndrome
- Is Targretin prescribed for: ☐ primary treatment of CTCL ☐ relapsed or persistent CTCL ☐ refractory or progressive CTCL
- Has the patient received prior systemic therapy for CTCL? ☐ Yes ☐ No
  - If yes, please indicate prior systemic therapy:

☐ Retinoids (eg. Bexarotene, all-trans retinoic acid)
☐ Interferons (eg, interferon-alpha)
☐ Histone deacetylase inbibitors
☐ Extracorporeal photophoresis
☐ Denileukin diftitox
☐ Methotrexate
☐ Liposomal doxorubicin
☐ Gemcitabine
☐ Chlorambucil
☐ Pentostatin
☐ Etoposide
☐ Cyclophosphamide
☐ Temozolomide
☐ Bortezomib
☐ Pralatrexate

- Is the CTCL refractory or progressive to skin-directed therapy? ☐ Yes ☐ No
- Is CTCL characterized by any of the following? (please check all that apply)

☐ Blood involvement
☐ Folliculotropic or large cell transformation
☐ Patch/plaque disease
☐ Limited extent tumor disease
☐ Generalized extent tumor disease

- Will Targretin be used in combination with systemic therapy or combination therapy? ☐ Yes ☐ No

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Targretin® Capsules (bexarotene)				
☐ Targretin® Gel 1% (bexarotene)				

X _____
PRODUCT SUBSTITUTION PERMITTED (Date)

X _____
DISPENSE AS WRITTEN (Date)