



**MEDICAID / CHIP**  
**PHARMACY PRIOR AUTHORIZATION REQUEST FORM**

**Bexarotene Gel - Non-PDL**

Phone: 866-841-7659

Fax back to: 866-240-3712

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.**

Member Name:		Prescriber Name:	
Member ID Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Member Phone Number:	NPI:	PA PROMISe ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):		
Drug Name:	Strength:		
Quantity:	Refills:		
Directions:			
Diagnosis Code:	Diagnosis:		
<i>Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..</i>			

**Please attach any pertinent medical history including labs and information for this member that may support approval.**

***Please answer the following questions and sign.***

Q1. Is this a renewal request? If yes, go to 2. If no, go to 5.

Yes

No

Q2. Has the patient been previously approved for bexarotene gel for the treatment of cutaneous lesions in patients with CTCL?

Yes

No

Q3. Is the patient female?

Yes

No

Q4. Is there a confirmed negative pregnancy test and contraception plan in place throughout treatment course?

Yes

No

Q5. Is the patient equal to or greater than 18 years of age?

Yes

No



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Member Name:	Prescriber Name:
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Q6. Is the medication being prescribed by or in consultation with an oncologist or dermatologist?

Yes

No

Q7. Is this prescribed for the treatment of an FDA approved indication?

Yes

No

Q8. Does the patient have an intolerance, contraindication or therapeutic failure to one prior treatment: such as surgical excision, radiation, phototherapy, topical corticosteroids, topical imiquimod, systemic or topical chemotherapy (mechlorethamine [nitrogen mustard], carmustine)?

Yes

No

Q9. Is the patient a female?

Yes

No

Q10. Is there a confirmed negative pregnancy test prior to starting therapy and contraception plan in place throughout treatment course?

Yes

No

Q11. Additional Information:

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

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