UPMC HEALTH PLAN

TARGRETIN
Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.
Otherwise please return completed form to:
UPMC HEALTH PLAN PHARMACY SERVICES PHONE 800-979-UPMC (8762) FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY. ***Incomplete responses may delay this request.***

Office Contact:	**Provider Specialty:**
Provider First Name:	**Provider Last Name:**
Provider Phone:	**Provider Fax:**

Patient Name:	**Patient UPMC Health Plan ID Number:**	**Patient Age:**	**Patient DOB:**

Drug Requested: ❑ **Brand** ❑ **Generic**	**Strength:**	**Frequency:**	**Expected length of therapy:**

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

❑ **New medication** ❑ **Ongoing medication**	**If ongoing, provide date started:**	**If medication is ongoing, Did member Show improvement while on therapy?**	❑**Yes** ❑**No**

Place of administration?	❑**Physician Office** ❑**Hospital/Facility**	**Please indicate how medication will be billed:** ❑ **Billed directly by the provider via JCODE** **Provide JCODE:**_____ ❑ **Billed by a pharmacy and delivered to the provider** ❑ **Billed by a pharmacy and delivered to the patient**
Please provide facility/provider name and address:		

Please provide pertinent progress notes and lab/radiology reports that describe the member's current disease status.

☐ **Chart documentation enclosed** ☐ **Chart documentation not available**

Please indicate the diagnosis and answer the corresponding questions:

❑ T-cell lymphoma	Does member have cutaneous manifestations of T-cell lymphoma?	❑Yes ❑No
	Was member refractory to at least one other prior systemic therapy? If yes, please list below:	❑Yes ❑No

Medication Name	Strength/Frequency	Dates of Therapy	Reason for Discontinuation

❑ Other Diagnosis, please list:	Please provide clinical literature/studies to support request for off-label use. ☐ Clinical literature/studies enclosed ☐ Clinical literature/studies not available

Is Targretin being used in combination with any other therapies? ❑Yes ❑No If yes, please list below.

Medication Name	Strength/Frequency	Dates of Therapy

Please list below any other previous therapies tried:

Medication Name	Strength/Frequency	Dates of Therapy	Reason for Discontinuation

Please provide any additional information which should be considered in the space below: