Please complete ALL information below and fax your request to 1-888-671-5285

Topical Antineoplastic Agents Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			**Provider Information** (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Actinic keratosis (AK) [**Picato** and **Solaraze (diclofenac 3% gel)** only]

❑ Cutaneous lesions in patients with cutaneous T-cell lymphoma [CTCL] (Stage IA and IB) who have refractory or persistent disease after other therapies or who have not tolerated other therapies [**Targretin** only]

❑ Stage IA and IB mycosis fungoides-type cutaneous T-cell lymphoma in patients with prior skin-directed therapy [**Valchlor** only]

❑ Other diagnosis: ______________________________ ICD-10 Code(s): ______________________________

Reauthorization:

For Picato and Solaraze (diclofenac 3% gel) requests, answer the following:

Is there a diagnosis of actinic keratosis at a different treatment site? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.

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