USAble Administrators

Physician's Prior Authorization Questionnaire
Targretin®

Patient: **ID#:** **DOB:**

Patient Address:

Targretin® is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. What is the patient's diagnosis? (*Please do not use codes.*) ______________________________

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2. If female, is the patient pregnant? ☐ Yes ☐ No ☐ Not Applicable

3. What dosage form of Targretin® is being prescribed? ______________________________

   If capsules, answer the following questions:

   Are the fasting lipid and triglyceride profiles within normal limits? ☐ Yes ☐ No

   If no, which medication(s) is the patient taking for the elevated levels? ____________________

   ____

______________________________ ______________________________

Physician's Signature Date

______________________________ ______________ / ______________

Please **Print** Physician's Name & Specialty Phone Number Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.usableadmin.com/providers/PharmacyForms.aspx