Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial Individual (Optimized)** ☒ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Zolinza® (vorinostat)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

Drug product: ☐ Zolinza 100 mg capsule

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Each fill of Zolinza is limited to a 14 day supply at any network pharmacy. Patients are responsible for applicable deductible and copayments.

Drug cost information

The wholesale acquisition cost for each Zolinza capsule is $125.08. The annual cost of treatment with this drug is more than $182,616.80 each year.

Prior authorization criteria

For this drug to be covered, the patient must meet the following criteria:

1. Diagnosis of cutaneous T-cell lymphoma
2. Must first try two of the following therapies:
   - One retinoid (such as bexarotene all-trans retinoic acid, isotretinoin, or acitretin)
   - One interferon (alpha or gamma)
   - Extracorporeal photopheresis

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 09/2013

Last reviewed 03/2019

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ cutaneous T-cell lymphoma
- ☐ *Other – the patient's condition is:* _____

B. What other drug therapies has the patient tried?

Drug name: _____
Drug name: _____

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