Zolinza®

Products affected

- Zolinza®

Details

Covered uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion criteria	N/A
Required medical information	N/A
Age restrictions	N/A
Prescriber restrictions	N/A
Coverage duration	Authorized for one year.
Other criteria	For diagnosis of primary cutaneous T-cell lymphoma, patient must have prior use of two of the following systemic therapies: a retinoid (bexarotene, all-trans retinoic acid, isotretinoin, acitretin), an interferon (IFN-alpha, IFN-gamma), methotrexate, or extracorporeal photopheresis.