CVS CAREMARK

Fax Referral To: 800-323-2445

Phone: 866-278-6634

Zolinza® (vorinostat)
Enrollment Form
For Blue Cross Blue Shield of Rhode Island Members

Date: _____ **Needs by Date (Please Specify):** _____

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other:** _____

PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
SS #: _____
Insurance ID: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____
Contact Phone: _____

INSURANCE INFORMATION *(If available, please copy and attach the front and back of insurance and prescription drug card)*

Primary Insurance: Subscriber: _____ Subscriber ID#: _____ Name of Insurer: **Blue Cross Blue Shield of RI**

Secondary Insurance: Subscriber: _____ Subscriber ID#: _____ Name of Insurer: _____

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Diagnosis (ICD-9 code): ☐ 202.1 Cutaneous T-cell Lymphoma (Mycosis Fungoides) ☐ 202.2 Cutaneous T-cell Lymphoma (Sezary's Disease)
☐ Other: _____ • Date of Diagnosis: _____

APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

• Patient has a diagnosis of cutaneous T-cell lymphoma ☐ Yes ☐ No

• If no, please specify diagnosis: _____

• Patient has received at least two prior therapies including, but not limited to (check all that apply): ☐ Yes ☐ No

☐ Topical methclorethamine or topical carmustine	☐ Denileukin diftitox	☐ Chlorambucil	☐ Fludarabine
	☐ Interferon	☐ Doxarubicin	☐ Cladarabine
☐ Psoralen + ultraviolet A (PUVA)	☐ Gemcitabine	☐ Isotretinoin	☐ Glucocorticoids (e.g., prednisone, dexamethasone)
☐ Methotrexate	☐ Cyclophosphamide	☐ Pentostatin	☐ Photophoresis (extra-corporeal photochemotherapy)
☐ Bexarotene			

Note: The following compendia, American Hospital Formulary Service, U.S. Pharmacopeia Dispensing Information, National Comprehensive Cancer Network NCCN), and Drug & Biologics Compendium™ Category of Evidence and Consensus are considered during prior authorization review if the drug is being prescribed for a condition not listed above. Additional information may be requested if documentation in the compendia is lacking.

Medical Necessity (please attach all supporting documentation):

_____

_____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Zolinza® (vorinostat)	☐ 100mg capsules			

_____ PRODUCT SUBSTITUTION PERMITTED (Date)

_____ DISPENSE AS WRITTEN (Date)