



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

- | | | | |
|--|--|---------------------------------------|--|
| <input type="checkbox"/> Topical methchloroethamine | <input type="checkbox"/> Denileukin diftitox | <input type="checkbox"/> Chlorambucil | <input type="checkbox"/> Fludarabine |
| <input type="checkbox"/> or topical carmustine | <input type="checkbox"/> Interferon | <input type="checkbox"/> Doxorubicin | <input type="checkbox"/> Cladarabine |
| <input type="checkbox"/> Psoralen + ultraviolet A (PUVA) | <input type="checkbox"/> Gemcitabine | <input type="checkbox"/> Isotretinoin | <input type="checkbox"/> Glucocorticoids (e.g., prednisone, dexamethasone) |
| <input type="checkbox"/> Methotrexate | <input type="checkbox"/> Cyclophosphamide | <input type="checkbox"/> Pentostatin | <input type="checkbox"/> Photophoresis (extra-corporeal photochemotherapy) |
| <input type="checkbox"/> 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
<input type="checkbox"/> Zolinza® (vorinostat)	<input type="checkbox"/> 100mg capsules			

PRODUCT SUBSTITUTION PERMITTED

(Date)

DISPENSE AS WRITTEN

(Date)

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. Zolinza PAB 092908