

Important Information About Prescription Drug Coverage

To: _____ From: _____

Fax: _____ Pages: _____

Re: Zolinza® (vorinostat): Prior Authorization Request Form: Please respond.

- Please complete the attached Zolinza® (vorinostat) Prior Authorization Request Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

Please note: By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

Information about this drug

Zolinza® (vorinostat)

While Zolinza® represents a new treatment option for Cutaneous T-cell lymphoma (CTCL), its effectiveness does not appear to be superior to current treatment options. The roughly 30% response rate in advanced CTCL is similar to responses observed with other commonly used therapies (e.g., oral Targretin®, methotrexate). Additionally, Zolinza® is not without significant safety issues. Pulmonary embolism occurred in 2.3% to 4.7% of patients, thrombocytopenia in 25.6% and anemia in 14.0%. The risk of QTc prolongation should also be noted by clinicians. If oral Targretin® failure is due to hypertriglyceridemia, consider therapy with fenofibrate and/or a statin before progressing to Zolinza® therapy.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.

Prior Authorization Request Form

Avera Advantage™

Fax completed form to 1-866-868-0858 Need help? Call 1-866-316-6049

Patient Information

Name _____
Member ID _____
Medicare ID _____
Date of birth _____ Sex: M / F
Address _____
City _____
State _____ ZIP _____
Phone _____
Nursing home resident? YES / NO
Home care patient? YES / NO

Prescriber and Pharmacy Information

Name _____
Specialty _____
DEA _____
NPI _____
Address _____
City _____
State _____ ZIP _____
Phone _____ Fax _____
Pharmacy name _____
NCPDP _____
NPI _____
Phone _____ Fax _____

All items below this line are for Physician Use Only

Information for Requested Drug

Strength: _____ Dosage form: _____ Qty per 30 days: _____ Drug is (circle one): Newly prescribed/Refill
Directions: _____ Diagnosis: _____ ICD-9 Code: _____

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

Zolinza® (vorinostat) Criteria

- 1 Please indicate the patient's diagnosis. Select or indicate the correct ICD-9 code. This question must be completed.
 CTCL (ICD-9: 202.1, 202.2) _____
 Other:(diagnosis and ICD-9 code): _____
- 2 Has the patient progressed to CTCL stage IIB or higher (i.e., III, IVA, IVB)?
 Yes No Not applicable
- 3 Is the prescribing physician an oncologist or hematologist?
 Yes No
- 4 Has the patient failed at least a 30 day trial on methotrexate AND oral Targretin®?
 Yes No

Medical Justification: (Attach additional page if necessary): _____

Prescriber's signature: _____ Date: _____