Zolinza (vorinostat)

Prior Authorization Form Curascript Fax (888) 773-7386

Last Name	First Name	Prescriber's Name	Specialty
Home Phone	Work Phone	Office Phone	Office Fax
Home Address / City / State / ZIP		Address / City / State / ZIP	
SCAN ID number	Date of Birth	Est. Start Date	Office Contact
For Specialty Medications Only: Shipping Address (if different from home address) ☐ Physician ☐ Home		Special Instructions (i.e. Non-English Speaking Patient, etc.)	

Medication:		Diagnosis:	
Sig:	Qty:	Refills:	ICD 9 Code:

Secondary/ Supplemental Insurance Company	Phone	Name of Insured	ID Number	Group Number

1. **Is the diagnosis or indication for the treatment of progressive, persistent, or recurrent cutaneous T-cell lymphoma?**
2. **Is the prescription initially recommended or written by an Oncologist?**
3. **Has the patient tried and failed two or more systemic therapies (Targretin, Actimmune, Roferon-A, methotrexate)?**
4. **Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel is important to this review?**

Physician's Signature: ____NPI/DEA #: ______________________ Date:

For Internal Use Only
☐ Approved ☐ Denied Reviewer's Initials ___________________ Decision Date __________________
Comments____

Notice: **Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.** Our response time for prescription drug coverage requests is 72 hours. View our formulary and Prior Authorization forms online at http://www.scanhealthplan.com.