SoonerSelect | aetna

State of Oklahoma
Oklahoma Health Care Authority

Zolinza® (Vorinostat) Prior Authorization Form

***Member Name:*__________________ *Date of Birth:*_____________ *Member ID#:*__________________**

Drug Information

***Pharmacy billing* (NDC:_____________________) *Start Date (or date of next dose):*__________________**

***Dose:*______________________________________ *Regimen:*____________________________________**

Billing Provider Information

***Provider NPI:*___________________________ *Provider Name:*__________________________________**

***Provider Phone:*___________________________ *Provider Fax:*_________________________________**

Prescriber Information

***Prescriber NPI:*______________________ *Prescriber Name:*___________________________________**

***Prescriber Phone:*______________ *Prescriber Fax:*_______________ *Specialty*:__________________**

Criteria

For Initial Authorization:

1. Please indicate the diagnosis and information:
   - ❑ **Primary Cutaneous Lymphomas – Mycosis Fungoides (MF)/Sézary Syndrome (SS)**
     - A. Will vorinostat be used as a single agent? Yes☐ No☐
     - B. Will vorinostat be used as primary treatment? Yes☐ No☐
     - C. Is disease relapsed or refractory? Yes☐ No☐
   - ❑ **If answer is none of the above, please indicate diagnosis:**_________________________

Additional Information:____

____

For Continued Authorization:

1. Date of last dose:_____________________
2. Does patient have any evidence of progressive disease while on vorinostat? Yes☐ No☐
3. Has the member experienced any adverse drug reactions related to vorinostat? Yes☐ No☐

*If yes, please specify adverse reactions:*____

____

Additional Information:____

____

Prescriber Signature:________________________________ **Date:**____________________________

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma.**	<u>CONFIDENTIALITY NOTICE</u> *This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*