

Complete Patient and Physician information (PLEASE PRINT)

STEP
1

Member Name:	Physician Name:
Address:	Address:
Member ID:	Phone #:
Member DOB:	Fax #:
	Tax ID or NPI #:

If Applicable: Pharmacy Name: _____
Pharmacy Phone: _____

Complete the Clinical Assessment:

STEP
2

Diagnosis:	<input type="checkbox"/> Cutaneous T Cell Lymphoma (CTCL) CTCL Type: _____	<input type="checkbox"/> Other (please state): _____
Clinical Consideration:	<input type="checkbox"/> ≥ 2 Prior Systemic Therapies for CTCL Approval requires 2 prior systemic therapies. <i>Examples:</i> Targretin, Ontak, Campath, Interferon alpha, various chemotherapy regimens.	Specific Therapies Used: 1. _____ 2. _____ 3. _____
Physician Specialty:	<input type="checkbox"/> Oncology <input type="checkbox"/> Other (please state): _____	
Supporting Documentation	Diagnosis: ICD-9 Code #/ Description / J Code (required): _____	
	Please attach a copy of the prescription or provide ALL of the information below: Zolinza [®] (vorinostat) Strength _____ Sig _____ Qty _____ Refills _____	
	Please attach all relevant medical records and test results. Incomplete forms will not be processed.	

STEP
3

I certify that the above is correct and accurate to the best of my knowledge (please sign and date).

Prescriber Signature _____ Date _____

STEP
4

**Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk:
970-248-5034**

Name of Person filling out form: _____

Pharmacy Technician initials _____ Date Initiated _____

Confidentiality Notice:

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