

**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-9/10 Code #/ Description / J Code (required):	
	Please attach a copy of the prescription or provide ALL of the information below: Zolinza <sup>®</sup> (vorinostat) Strength _____ Sig _____ Qty _____ Refills _____	
	*Please attach all relevant medical records and test results* <b>We will not process incomplete forms.</b> <b>If we do not receive the completed form &amp; all relevant medical records &amp; test results within 10 calendar days of this request, it will be denied.</b>	

STEP  
3

I certify that the above is correct and accurate to the best of my knowledge and that the form is complete.  
 (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:**

This facsimile transmission (and/or documents accompanying it) may contain confidential information. This information is intended only for the use of the individual(s) named above. If you have received this transmission in error, or cannot identify the recipient for distribution purposes, please notify us immediately at 970-244-7760. Plans underwritten by Rocky Mountain HMO or Rocky Mountain HealthCare Options. 04/13/10