P.O. Box 30192
Salt Lake City, UT 84120-0192
801-442-4912 or 800-442-3219
Fax 801-442-3006

selecthealth℠

PREAUTHORIZATION FORM

Zolinza™
(vorinostat)

Therapeutic use: Treatment of cutaneous manifestations in patients with cutaneous T-cell lymphoma
Quantity Limit: 4 capsules per day
Authorization Period: 12 months

Patient's name _____

Patient's ID# ☐☐☐ ☐☐ ☐☐☐☐ DOB ☐☐/☐☐/☐☐☐☐

ICD-9 ☐☐☐ ☐☐ ☐☐☐ ☐☐ _____

Physician's name_____

Physician's Ph# (☐☐☐) ☐☐☐-☐☐☐☐ Fax# ☐☐☐-☐☐☐☐

Physician's signature_____ Date signed ☐☐/☐☐/☐☐☐☐

Supervising Physician's name_____ (Required if requesting provider is a nurse practitioner or physician assistant)

Please check "Yes" or "No" and respond to the following requests:			
1.	Has the patient been diagnosed with Cutaneous T-cell Lymphoma (CTCL)?	❑ Yes	❑ No
2.	Does the patient have progressive, persistent or recurrent disease?	❑ Yes	❑ No
3.	Has the patient been tried on *at least 2* systemic therapies?	❑ Yes	❑ No

Treatment	Dates of therapy
1.	
2.	
3.	
4.	

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

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