

**Health New England**  
**Medication Request Form (MRF)/Prescription Request**  
**Zolinza® (vorinostat)**

|                                                        |
|--------------------------------------------------------|
| DO NOT WRITE IN BLOCKED AREAS<br>FOR INTERNAL USE ONLY |
| Contacted:                                             |
| Physician:                                             |
| Pharmacy:                                              |
| Patient:                                               |
|                                                        |
|                                                        |

**Prior Authorization**

|                                                        |
|--------------------------------------------------------|
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| Approved:                                              |
| Quantity approved:                                     |
| PA from and thru date:                                 |
| PA #                                                   |
| Denied:                                                |
| Returned:                                              |

**Instructions:**

This form is to be used by participating physicians and pharmacy providers to obtain coverage of (Zolinza®). Please complete this form and fax to ICORE Healthcare at (800)-349-5058. If you have any questions regarding this process, please contact ICORE Healthcare at (800)-350-8119.

**J-Code: J8499**

**Medication Request Information (please complete each section of this form prior to transmittal):**

| Patient Information (all required)         | Physician Information (all required)   |
|--------------------------------------------|----------------------------------------|
| <b>Patient Name:</b>                       | <b>Physician Name:</b>                 |
|                                            | <b>Specialty:</b>                      |
| <b>Patient Cell Phone #: (     )     -</b> | <b>NPI#:</b>                           |
| <b>Patient HNE ID#:</b>                    | <b>HNE Provider #:</b>                 |
| <b>Patient Date of Birth:</b>              | <b>DEA #:</b>                          |
| <b>Allergies:</b>                          | <b>Telephone #: (     )     -</b>      |
| <b>Diagnosis:</b>                          | <b>Fax # (required): (     )     -</b> |

**Drug Information**

|                                                                                                                               |                              |                 |
|-------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------|
| <b>Requested Drug/Strength/Form:</b> <input type="checkbox"/> <b>Zolinza</b> HNE covers a maximum of 120 capsules per 30 days |                              |                 |
| <b>Dose, Directions, and length of treatment (please be specific):</b>                                                        | <b>Quantity (per month):</b> | <b>Refills:</b> |
|                                                                                                                               |                              |                 |
| <b>Physician Signature:</b>                                                                                                   | <b>Date:</b>                 |                 |
|                                                                                                                               |                              |                 |

**Indication:**

- The treatment of cutaneous manifestations in patients with cutaneous T-cell lymphoma (CTCL) who have progressive, persistent or recurrent disease on or following two systemic therapies
- Other (please describe): \_\_\_\_\_

**Documentation of Medical Necessity (check all that apply):**

- The prescribing physician is a hematologist or oncologist
- Member is an adult
- \_\_\_\_\_ has been tried as first line therapy
- If female, pregnancy has been ruled out and member is using birth control
- Other pertinent history: \_\_\_\_\_