



Send completed form to:
Peach State Health Plan Pharmacy Department
Fax: 1-866-374-1579

Zolinza

Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copay or medication delivery; please contact Peach State Health Plan at **1-800-514-0083 option # 2.**

Patient Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Physician Office Address: _____

1. What drug is being prescribed? Zolinza Dose: _____ Frequency: _____
 Other _____
2. What is the diagnosis? Cutaneous T-cell lymphoma (includes mycosis fungoides and Sezary syndrome) Other _____
3. What is the ICD9? _____
4. Does the patient have progressive, persistent, or recurrent disease on or following **two** systemic therapies (e.g., retinoids, interferons, histone deacetylase inhibitors, extracorporeal photophoresis, denileukin diftitox, methotrexate, liposomal doxorubicin, gemcitabine, chlorambucil, pentostatin, etoposide, cyclophosphamide, temozolomide, bortezomib, pralatrexate)? Yes No
5. Is the patient currently receiving Zolinza therapy? Yes No *If No, no further questions*
6. Is the patient experiencing disease progression or unacceptable toxicity while on Zolinza?
 Yes No

*****NOTE:: We can NOT make a decision without documentation - Thank You*****

Information given on this form is accurate as of this date:

X _____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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