



Zolinza[®] Prior Authorization Request Form

Please fax the completed request form to Mercy Health Plans Pharmacy Department
at 314-214-8201 or 800-647-2240. For additional information please call 314-214-8282 or 800-647-2240.

Patient Name: _____ Today's Date: ____/____/____
 Patient Pharmacy ID: _____ Date of Birth: ____/____/____
 (located on bottom right of insurance card)
 Requesting Physician: _____ Specialty: _____
 (Please print)
 Office Contact Person: _____ Phone #: (____)____-____ ext ____
 Office Address: _____
 Medication/dose Requested: _____ Fax #: (____)____-____
 Expected Duration of Therapy: _____ ICD-9: _____

Please circle YES or NO:

- | | | |
|---|-----|----|
| 1. Does the patient have a diagnosis of cutaneous T-cell lymphoma (CTCL) ? | YES | NO |
| <input type="checkbox"/> Does the patient have cutaneous manifestations? | YES | NO |
| <input type="checkbox"/> Does the patient have progressive, persistent, or recurrent disease despite treatment? | YES | NO |

Please list therapies the patient has previously tried, below.

Medication	Dose	Date	Therapeutic Outcome

If the patient has NOT tried Targretin (bexarotene) for the treatment of CTCL, please list reason.

Physician's Signature: _____ Date: ____/____/____

For Mercy Health Plans use only:

Approved Length of Approval _____
 Denied Reason for Denial _____
 Reviewer's Signature: _____ Date Reviewed: ____/____/____
 Override Entered in Caremark CCMS for _____ - _____ by _____
 Office Notified on _____; at _____ am/pm; by _____ spoke to _____