PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Zolinza - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**. Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Zolinza - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Zolinza (vorinostat)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Has the plan authorized this medication in the past for this patient (i.e., previous (i.e., previous authorization is on file under this plan)? Y N

NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.

[If yes, skip to question 6.]

2. Does the patient have a documented diagnosis of cutaneous T-cell lymphoma (CTCL)? Y N

	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
3.	Does the patient have documented progressive, persistent, or recurrent disease on or following two systemic chemotherapeutic therapies?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
4.	Does the patient have a documented treatment plan including laboratory monitoring tests of blood glucose, serum electrolytes, serum creatinine, and complete blood count to be performed for all of the following: A) at baseline, B) every two weeks for the first two months of therapy, and C) monthly thereafter?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
5.	Does the patient have a documented treatment plan including baseline and periodic electrocardiogram (ECG) to be performed throughout the requested drug therapy?	Y N	
	NOTE: Submission of medical records is required.		
	[No further questions.]		
6.	Is there clinical documentation showing the patient has had a beneficial treatment response?	Y N	
	NOTE: Submission of medical records is required.		

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date