UnitedHealthcare Community Plan

# Zolinza

# PRIOR AUTHORIZATION REQUEST FORM

Please complete this entire form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
**This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.**
**Allow at least 24 hours for review.**

## Section A – Member Information

| | | |
|---|---|---|
| First Name: | Last Name: | Member ID: |
| Address: | | |
| City: | State: | ZIP Code: |
| Phone: | DOB: | Allergies: |
| Primary Insurance: | Policy #: | Group #: |

**Is the requested medication □ New or □ Continuation of Therapy? If continuation, list start date: _____**
**Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____**

## Section B - Physician Information

| | | | |
|---|---|---|---|
| First Name: | | Last Name: | M.D./D.O. |
| Address: | | City: State: | ZIP code: |
| Phone: | Fax: | NPI #: | Specialty: |

## Section C - Medical Information

**Medication:** **Strength:**

**Directions for use:** **Quantity:**

**Diagnosis** (Please be specific & provide as much information as possible)**:** **ICD-10 CODE:**

**Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____**

## Section D – Previous Medication Trials

| Medications | Strength | Directions | Dates of Therapy | Reason for failure / discontinuation |
|---|---|---|---|---|
| | | | | |
| | | | | |

## Section E – Clinical and Drug Specific Information

**- Does the patient have a diagnosis of cutaneous T-cell lymphoma? □ Yes □ No**

**- Does the patient have a history of failure, contraindication, or intolerance to at least two systemic therapies?**
□ **Yes** □ **No** (If yes, complete Section D above with medication information, including dose, duration, date of trial, and reason for discontinuation)

**- In continuation, does the patient show evidence of progressive disease while on Zolinza therapy? □ Yes □ No**

## Section F – Additional information and Explanation of why preferred medications would not meet the patient's needs

***Please refer to www.uhccommunityplan.com for a list of preferred alternatives***

**Physician Signature: _____ Date: _____**