

**PRIOR AUTHORIZATION PROGRAM REIMBURSEMENT REQUEST FORM**

Please fax form to:  
1-866-840-1509

**For cancer therapy: Zolinza (vorinostat)**

Please note that the patient AND physician must complete this form. All fields are mandatory and must be completed. Incomplete forms may result in your application being declined. Please retain a copy of this form for your records.

**Instructions:**

1. PLEASE PRINT CLEARLY AND COMPLETE ALL SECTIONS.
2. The patient/plan member must complete section A.
3. Your physician must complete section B. The cost, if any, of completing this form is at the expense of the patient/plan member.
4. Please return the form to your insurance company via Pharmacy Services at TELUS Health (a service provider of your insurance company) by fax to 1-866-840-1509.
5. If you have any questions on the application of this program or the decision on reimbursement, or to inquire on the status of your Reimbursement Request Form, please contact your insurer.

**A. Information to be Completed by Patient**

Employee or Insured's Name	Drug Card Number	
Patient's Name	Patient's Date of Birth (D/M/Y) / /	Relationship to Employee/Insured (please circle) Employee Spouse Dependant

**Please allow two business days for a response once all information is received and complete. Notification of the results of this request will occur Monday to Friday between 9 am and 4 pm Eastern Time.**

Please provide contact information and indicate ONE method of preferred contact for notification of the results:

- e-mail me at: \_\_\_\_\_
- call me (and leave a message if I'm not there) at: (\_\_\_\_\_) \_\_\_\_\_
- fax me at: (\_\_\_\_) \_\_\_\_\_
- contact my pharmacy at pharmacy name: \_\_\_\_\_ phone no: (\_\_\_\_) \_\_\_\_\_

I certify that the information provided by me is true, correct and complete to the best of my knowledge. I authorize my insurance company, TELUS Health (a service provider of my insurance company), their authorized representatives, agents and service providers to use and exchange this information needed for underwriting, administration and paying claims with any person or organization who has relevant information pertaining to this claim including health professionals, institutions and investigative agencies in the event of an audit. I authorize my insurance company and/or TELUS Health (a service provider of my insurance company) to contact any licensed physician, institution, pharmacy or person who has any records or knowledge of me or my health with respect to this submitted claim.

SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN \_\_\_\_\_ Date (D/M/Y): \_\_\_\_\_

**B. Information to be Completed by Prescribing Physician**

Drug Name: \_\_\_\_\_ Strength: \_\_\_\_\_ Dose: \_\_\_\_\_

Zolinza will be eligible for reimbursement only if the patient satisfies one or more of the criteria listed below and does not qualify for coverage under any other drug plan or government mandated program. If the patient is covered under another drug plan or government mandated program, the prior authorization program, as part of your drug benefits, may cover the portion not paid for by the primary plan. Please note that the drug may be eligible for reimbursement only if the patient receives it for Health Canada approved indication(s). However, if "none of the above criteria" is indicated, the patient will not be eligible for reimbursement. For Quebec plan members, please refer to the RAMQ exception drug criteria, if applicable.

Please indicate if the patient satisfies one of the following criteria:

- For the treatment of cutaneous manifestations in patients with advanced cutaneous T-cell lymphoma (CTCL) who have progressive, persistent or recurrent disease subsequent to prior systemic therapies (400122007).

OR

- None of the above criteria applies.

Relevant additional information \_\_\_\_\_

Physician's Name	License Number	Telephone Number	Fax Number
Address		City	Province Postal Code
Physician's Signature			Date (DD/MM/YYYY)