

**Physician's Prior Authorization Questionnaire  
Vesanoid®**

**Patient:**

**ID#:**

**DOB:**

**Patient Address:**

Vesanoid® is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. Does the patient have a diagnosis of Acute Promyelocytic Leukemia?  Yes  No
2. Does the patient have a diagnosis of Kaposi's Sarcoma?  Yes  No
3. Does the patient have a diagnosis of Mycosis Fungoides or Sezary Syndrome?  Yes  No
4. If the answer to the above three questions is no, what is the diagnosis? *(Please do not use codes.)*

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\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please **Print** Physician's Name & Specialty

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

*Forms are also available online at [www.usableadmin.com/providers/PharmacyForms.aspx](http://www.usableadmin.com/providers/PharmacyForms.aspx)*