



Please complete ALL information below and fax your request to 1-888-671-5285

### Votrient® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

### Medication Information (required)

Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if <b>generic substitution</b> is acceptable	Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>		

### Clinical Information (required)

**Select the diagnosis below:**

Renal cell carcinoma (RCC)

Soft tissue sarcoma (STS)

Other diagnosis: \_\_\_\_\_ ICD-10 Code(s): \_\_\_\_\_

**Prescriber's specialty:**  
Is **Votrient** prescribed by or in consultation with an oncologist?  **Yes**  **No**

**For renal cell carcinoma (RCC), answer the following:**  
Does the patient have advanced or metastatic disease?  **Yes**  **No**

**For soft tissue sarcoma (STS), answer the following:**  
Does the patient have advanced soft tissue sarcoma (STS)?  **Yes**  **No**  
Has the patient received at least one prior chemotherapy (e.g., ifosfamide, doxorubicin, cisplatin, dacarbazine, docetaxel, oxaliplatin, etc.)?  **Yes**  **No**

**Reauthorization:**  
**If this is a reauthorization request, answer the following question:**  
Does the patient show evidence of progressive disease while on **Votrient** therapy?  **Yes**  **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.

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