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:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

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?

_____

_____

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