Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Votrient® (pazopanib)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product: ☐ Votrient 200 mg tablet

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Oral oncology partial fill program

Each fill of Votrient is limited to a 14 day supply at any network pharmacy. Patients are responsible for applicable deductible and copayments.

Precertification Requirements

For this drug to be covered, the patient must have one of the following listed conditions:

☐ Advanced renal cell carcinoma
☐ Advanced soft tissue sarcoma after a trial with one other chemotherapeutic agent

☐ Other – the patient's condition is: _____
Rationale for use: _____

Additional information

Requests for any condition not listed as covered require evidence of current medical literature that substantiates the drug's efficacy or that recognized oncology organizations generally accept the treatment for the condition.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 09/2013
Last reviewed 07/2018