### Votrient (pazopanib) **Prior Authorization Request Form**

**Caterpillar Prescription Drug Benefit** Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

MEMBER INFORMATION				
LAST NAME:	FIRST NAME:			
PHONE NUMBER:	DATE OF BIRTH:			
STREET ADDRESS:				
CITY:	STATE: ZIP CODE:			
PATIENT INSURANCE ID NUMBER:				

MALE FEMALE HEIGHT (IN/CM): \_\_\_\_\_ WEIGHT (LB/KG): \_\_\_\_\_ ALLERGIES: \_\_\_\_\_

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

#### PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): \_\_\_\_\_

### AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: \_\_\_\_\_\_

PRESCRIBER INFORMATION			
LAST NAME:	FIRST NAME:		
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:		
NPI NUMBER:	DEA NUMBER:		
PHONE NUMBER:	FAX NUMBER:		
STREET ADDRESS:			
CITY:	STATE: ZIP CODE:		
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:		

MEDICATION OR MEDICAL DISPENSING INFORMATION					
MEDICATION NAME:					
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:		
		IF RENEWAL: DATE THERAPY INITIATED:			
DURATION OF THERAPY (SPECIFIC DATES):					

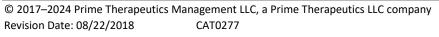
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MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:			
1. HAS THE PATIENT TRIED ANY OTHER	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) 📃 NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	<b>DURATION OF THERAPY</b> (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:		
2. LIST DIAGNOSES:		ICD-10:		
<ul> <li>Advanced renal cell carcinoma (RCC)</li> <li>Other diagnosis:</li></ul>	ICD-10			
<b>3. REQUIRED CLINICAL INFORMATION</b> PRIOR AUTHORIZATION.	PLEASE PROVIDE ALL RELEVANT CLINIC	AL INFORMATION TO SUPPORT A		
Clinical Information: Does the patient have stage 3 or 4 advanced renal cell carcinoma, as defined by the American Cancer Society staging system?*  Ves  No *Please provide documentation. Is the histology of the disease predominantly conventional (clear cell)?*  Ves  No *Please provide documentation. Select how Votrient is being used from the following:* As first line therapy As second line therapy As third line therapy or beyond *Submit clinical notes documenting clinical course and any past treatments tried.				
Reauthorization:	wer the following question:			
If this is a reauthorization request, answer the following question: Has the patient experienced tumor response with stabilization of disease or decrease in the size of tumor or tumor spread?*  Yes No *Please provide documentation.				
Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?				
<ul> <li>Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.</li> <li>ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical</li> </ul>				
information necessary to verify the accuracy of the information reported on this form.          Prescriber Signature or Electronic I.D. Verification:				





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#### FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program

Attn: CP – 4201 P.O. Box 64811 St. Paul, MN 55164-0811