UnitedHealthcare Community Plan

Votrient
PRIOR AUTHORIZATION REQUEST FORM

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form contains multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication □ New or □ Continuation of Therapy? If continuation, list start date: _____
Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Physician Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**
Is this member pregnant? □ Yes □ No	**If yes, what is this member's due date?** _____

Section D – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs
Please refer to www.uhccommunityplan.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

- What is the patient's diagnosis? (Check which apply)

□ Renal Cell Carcinoma (RCC) □ Soft Tissue Sarcoma (STS)
□ Thyroid Carcinoma □ Uterine Sarcoma
□ Metastatic Dermatofibrosarcoma Protuberans (DFSP) □ Ovarian Cancer
□ None of the above, list diagnosis: _____

Renal Cell Carcinoma (RCC):

- Is the patient's disease relapsed? □ Yes □ No

- Does the patient have a medically or surgically unresectable tumor? □ Yes □ No

- Does the patient have a diagnosis of Stage IV disease? □ Yes □ No

Soft Tissue Sarcoma (STS)

- What is the patient's diagnosis? (Check which apply)

□ Angiosarcoma □ Pleomorphic Rhabdomyosarcoma
□ Progressive Gastrointestinal Stromal Tumors (GIST) □ Retroperitoneal/Intra-abdominal of Non-Liposarcoma Origin
□ Soft Tissue Sarcoma of the Extremity/Superficial Trunk or Head/Neck, of Non-Liposarcoma Origin □ None of the above, list diagnosis: _____

- Is the patient's disease unresectable or progressive? □ Yes □ No

- Is the patient's disease synchronous stage IV or recurrent and has disseminated metastases? □ Yes □ No

- Does the patient have a history of failure, contraindication, or intolerance to any of the following (Gleevec (imatinib), Sutent (sunitinib), Stivarga (regorafenib))? □ Yes □ No (If yes, complete Section D above with medication information, including dose, duration, date of trial, and reason for discontinuation)

Thyroid Carcinoma:

- What is the patient's diagnosis? (Check which apply)

□ Follicular carcinoma □ Hürthle cell carcinoma
□ Papillary carcinoma □ Medullary Carcinoma
□ None of the above, list diagnosis: _____

- Does the patient have ONE of the following: (check which apply)

□ Unresectable Recurrent Disease □ Persistent Locoregional Disease □ Metastatic Disease □ None of the above

- Does the patient have ONE of the following: (check which apply)

□ Symptomatic Disease □ Symptomatic Disease with Distant Metastases □ Progressive Disease □ None of the above

- Is the patient's disease refractory to radioactive iodine treatment? □ Yes □ No

- Does the patient have a history of failure, contraindication, or intolerance to any of the following (Caprelsa (vandetanib), Cometriq (cabozantinib)? □ Yes □ No
(If yes, complete Section D above with medication information, including dose, duration, date of trial, and reason for discontinuation)

Ovarian Cancer:

- What is the patient's diagnosis? (Check which apply)

□ Epithelial Ovarian Cancer □ Fallopian Tube Cancer
□ Primary Peritoneal Cancer □ None of the above, list diagnosis: _____

- Does the patient have stage II-IV disease? □ Yes □ No

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Member First name:	Member Last name:	Member DOB:

- Is the patient in complete remission following primary treatment? □ Yes □ No

- Does the patient's disease meet one of the following:
□ Disease is persistent □ Disease is recurrent □ Neither

- Will Votrient be used as a single agent? □ Yes □ No

- Does the patient meet both of the following: □ Yes □ No
□ Disease is platinum resistant □ Votrient will be used in combination with weekly paclitaxel

Requests for Continuation of Therapy:

- Does the patient show evidence of progressive disease while on Votrient therapy? □ Yes □ No

Physician Signature: _____ Date: _____