

## PRIOR AUTHORIZATION REQUEST FORM

#### **EOC ID:**

# Votrient

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.** 

Patient Name:	Prescriber Name: Supervising Physician:	
		Dhana
Member/Subscriber Number:	Fax: Office Contact:	Phone:
Date of Birth: Group Number:	NPI:	State Lic ID:
Address:	Address:	State Lic ID.
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable)	:
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.		
Q1. Please provide the ICD code from the diagnosis provided.		
Q2. What diagnosis is this drug being prescribed for?		
Advance renal cell carcinoma (RCC)		
Advanced soft tissue sarcoma (STS)		
☐ Other		
Q3. If you selected "other" in question 2, please provide documentation that use is consistent with a category 1 or higher recommendation per NCCN compendia or guidelines.		
Q4. Is the prescribing physician an Oncologist or Hematologist?		
☐ Yes ☐ No		
Q5. If the diagnosis is advanced STS, has the patient received prior chemotherapy?		
☐ Yes ☐ No		
Q6. Does the patient have adipocytic soft tissue sarcoma?		
☐ Yes ☐ No		
I .		



error, please notify the sender immediately to arrange for the return of this document

### PRIOR AUTHORIZATION REQUEST FORM

#### **EOC ID:**

### Votrient

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process. **Prescriber Name: Patient Name:** Supervising Physician: Q7. Does the patient have gastrointestinal stromal tumors? □No **Q8.** Additional Comments: Prescriber Signature Date □ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided. This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in