BlueCross BlueShield Federal Employee Program

VOTRIENT
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Votrient (pazopanib)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Has the patient been on Votrient continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑ **YES** - this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 2**
   ❑ **NO** - this is **INITIATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑ Brand ❑ Generic
3. How many tablets does the patient need for 90 days? _____ tablet(s) per 90 days
4. What is the patient's diagnosis?
   ❑ Advanced Renal Cell Carcinoma (RCC)
   ❑ Advanced Soft Tissue Sarcoma (STS)
      a. Has the patient had inadequate treatment response with at least one previous chemotherapy regimen? ❑Yes ❑No
   ❑ Gastrointestinal stromal tumor
      a. Was there a prior inadequate treatment response with Gleevec (imatinib), Sutent (sunitinib), or Stivarga (regorafenib)? ❑Yes ❑No
   ❑ Metastatic Dermatofibrosarcoma Protuberans (DFSP)
   ❑ Recurrent or metastatic thyroid carcinoma
      a. What is the histology, or type, of thyroid carcinoma? ***Please select answer below:***
         ❑ Follicular carcinoma ❑ Hürthle cell carcinoma ❑Medullary carcinoma***** ❑ Papillary carcinoma
         ❑ Other ***(please specify)***: _____
      b. **If Medullary Carcinoma**: Has the patient had an inadequate treatment response or contraindication to Caprelsa (vandetanib) or Cometriq (cabozantinib)? ❑Yes ❑No
   ❑ Recurrent ovarian cancer
      a. Does the patient have epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer? ❑Yes ❑No
      b. Does the patient have stage II, III, or IV ovarian cancer? ❑Yes ❑No
      c. Was there complete remission following primary treatment? ❑Yes ❑No
   ❑ Uterine sarcoma
      a. What stage is the uterine sarcoma? ❑ Stage I***** ❑ Stage II ❑ Stage III ❑ Stage IV
      b. **If Stage I**: Is the disease medically inoperable? ❑Yes ❑No
   ❑ Other diagnosis ***(please specify):*** _____
5. Does the prescriber agree to monitor transaminase and bilirubin levels at least twice per month for the first three months and then periodically thereafter? ❑Yes ❑No
6. Does the patient have bilirubin levels less than 5.7 mg/dL? ❑Yes ❑No
7. Does the patient have severe hepatic impairment? ❑Yes ❑No

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Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Votrient (pazopanib)

***Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Has the patient been on Votrient continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑ **NO** - this is **INITIATION** of therapy, please answer the questions **PAGE 1**
   ❑ **YES** - this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below:

2. Is this request for brand or generic? ❑ Brand ❑ Generic

3. How many tablets does the patient need for 90 days? _____ tablet(s) per 90 days

4. What is the patient's diagnosis?
   ❑ Advanced Renal Cell Carcinoma (RCC)
   ❑ Advanced Soft Tissue Sarcoma (STS)
   ❑ Gastrointestinal stromal tumor
   ❑ Metastatic Dermatofibrosarcoma Protuberans (DFSP)
   ❑ Ovarian cancer
   ❑ Recurrent or metastatic thyroid carcinoma
   ❑ Uterine sarcoma
   ❑ Other diagnosis ***(please specify)***: _____

5. Has the patient had disease progression or unacceptable toxicity? ❑Yes ❑No

6. Does the patient have bilirubin levels less than 5.7 mg/dL? ❑Yes ❑No

7. Does the patient have severe hepatic impairment? ❑Yes ❑No

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***