Prescriber Criteria Form Votrient 2024 PA Fax 547-A v2 010124.docx Votrient (pazopanib) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Votrient (pazopanib).

Drug Name: Votrient (pazopanib)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of renal cell carcinoma? [If no, then skip to question 4.]	Yes	No
2	Will the requested drug be used for von Hippel-Lindau (VHL)-associated renal cell carcinoma? [If yes, then no further questions.]	Yes	No
3	Is the disease advanced, relapsed, or stage IV? [No further questions.]	Yes	No
4	Does the patient have a diagnosis of soft tissue sarcoma (STS)? [If no, then skip to question 6.]	Yes	No
5	Is the diagnosis adipocytic soft tissue sarcoma? [No further questions.]	Yes	No
6	Does the patient have a diagnosis of thyroid carcinoma? [If no, then skip to question 8.]	Yes	No
7	Does the disease express any of the following histologies: A) follicular, B) Hurthle cell, C) papillary, D) medullary? [No further questions.]	Yes	No

8	Does the patient have a diagnosis of uterine sarcoma? [If no, then skip to question 10.]	Yes	No
9	Is the disease recurrent or metastatic? [No further questions.]	Yes	No
10	Does the patient have a diagnosis of gastrointestinal stromal tumor (GIST)? [If no, then no further questions.]	Yes	No
11	Will the requested drug be used for unresectable succinate dehydrogenase (SDH)-deficient gastrointestinal stromal tumors (GISTs)? [If yes, then no further questions.]	Yes	No
12	Will the requested drug be used for the palliation of symptoms if previously tolerated and effective? [If yes, then no further questions.]	Yes	No
13	Is the disease unresectable, recurrent/progressive, or metastatic? [If no, then no further questions.]	Yes	No
14	Has the patient failed therapy on a Food and Drug Administration (FDA)-approved therapy (for example, imatinib, sunitinib, regorafenib, ripretinib)?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____