Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (MEDICAID)

Votrient (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health New Jersey at **1-855-296-0323**.
When conditions are met, we will authorize the coverage of Votrient (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

Votrient (pazopanib)

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Patient information

Patient name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis:_____ **ICD Code:**_____

Circle the appropriate answer for each question.

1. Has this plan authorized this medication in the past for this member (i.e. previous authorization is on file under this plan)? Y N

   [If no, skip to question 4.]

2. Does the member show evidence of progressive disease while on therapy? Y N

   [If yes, then no further questions]

3. Does the member have unacceptable toxicity from therapy? Y N

   [No further questions.]

4. Is Votrient requested for the treatment of advanced renal cell carcinoma? Y N

   [If yes, skip to question 16.]

5. Is Votrient requested for a member with advanced or metastatic soft tissue sarcoma (STS) AND any of the following: A) Angiosarcoma, B) Pleomorphic rhabdomyosarcoma, C) Unresectable or progressive retroperitoneal/intra-abdominal soft tissue sarcoma, or D) Recurrent or metastatic soft tissue sarcoma of the extremity, superficial trunk, head or neck? Y N

   [If yes, skip to question 16.]

6. Is Votrient requested for the treatment of metastatic dermatofibrosarcoma protuberans (DFSP)? Y N

   [If yes, skip to question 16.]

7. Is Votrient requested for the treatment of uterine sarcoma? Y N

   [If yes, skip to question 16.]

8. Is Votrient requested for the treatment of epithelial ovarian, fallopian tube, or primary peritoneal cancer? Y N

   [If no, skip to question 11.]

9. Is the request for a member who received primary treatment with chemotherapy (example: carboplatin with paclitaxel) and/or surgery AND is in a complete recurrent remission? Y N

   [If yes, skip to question 16.]

10. Is the request for a member who has persistent or recurrent disease AND Votrient will be used either as a single agent or in combination with paclitaxel if the member is platinum resistant? Y N

    [If yes, skip to question 16.]

    [If no, then no further questions]

11. Is Votrient requested for the treatment of progressive gastrointestinal stromal tumor (GIST)? Y N

    [If no, skip to question 13.]

12. Did progression occur while the patient was on treatment with imatinib (Gleevec) or sunitib (Sutent) or regorafenib (Stivarga)? Y N

[If yes, skip to question 16.]

[If no, then no further questions.]

13. Is Votrient requested for the treatment of locally recurrent or metastatic, progressive and/or symptomatic, differentiated thyroid carcinoma (including papillary, follicular, and Hurthle cell)? Y N

[If no, then no further questions]

14. Is the member refractory to radioactive iodine treatment? Y N

[If no, then no further questions]

15. Are other systemic therapies either not available or inappropriate for the member? Y N

[If no, then no further questions]

16. Is Votrient prescribed by, or in consultation with, an oncologist? Y N

[If no, then no further questions.]

17. Is the member 18 years of age or older? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature **Date**