

**Physician's Prior Authorization Questionnaire
Sutent®**

Patient:

ID#:

DOB:

Patient Address:

Sutent® is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. What is the patient's diagnosis? *(Please do not use codes.)* _____

2. If female, is the patient pregnant? Yes No

3. Has this patient tried other chemotherapy regimens? Yes No

If yes, please explain the patient's response to prior therapy below:

4. What dose is being requested (mg/day)? _____

The patient will not be able to get more than a 30 day supply per 45 days.

Sutent® will be shipped to the patient from our Specialty Pharmacy.

Physician's Signature

Date

Please **Print** Physician's Name & Specialty

Phone Number

Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.usableadmin.com/providers/PharmacyForms.aspx