

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

Patient:

ID#:

DOB:

Patient Address:

Votrient® 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? _____
2. Is the disease advanced or metastatic? Yes No
3. Does the patient have clear cell histology or predominant clear cell histology? Yes No

NOTE: Please fax in supporting medical records.

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