

**PRIOR AUTHORIZATION PROGRAM REIMBURSEMENT REQUEST FORM**  
**For cancer therapy: Votrient (pazopanib)**

Please fax form to:  
**1-866-840-1509**

Please note that the patient **AND** physician must complete this form. **All fields are mandatory and must be completed. Incomplete forms may result in your application being declined.** Please retain a copy of this form for your records.

**Instructions:**

- 1. PLEASE PRINT CLEARLY AND COMPLETE ALL SECTIONS.**
2. The patient/plan member must complete section A.
3. Your physician must complete section B. The cost, if any, of completing this form is at the expense of the patient/plan member.
4. Please return the form to your insurance company via Pharmacy Services at TELUS Health (a service provider of your insurance company) by fax to **1-866-840-1509**.
5. If you have any questions on the application of this program or the decision on reimbursement, or to inquire on the status of your Reimbursement Request Form, please contact your insurer.

<b>A. Information to be Completed by Patient</b>		
Employee or Insured's Name	Drug Card Number ____ - ____ - ____ - ____	
Patient's Name	Patient's Date of Birth (DD/MMM/YYYY) __ / __ / ____	Relationship to Employee/Insured <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent
<p><b>Please allow two business days for a response once all information is received and complete.</b>  <b>Notification of the results of this request will occur Monday to Friday between 9 am and 4 pm Eastern Time.</b></p>		

Please provide contact information and indicate **ONE** method of preferred contact for notification of the results:

<input type="checkbox"/> E-mail	<input type="checkbox"/> Call me (and leave a message if I'm not there)	<input type="checkbox"/> Fax me at:
<input type="checkbox"/> Contact my pharmacy: Pharmacy Name		Pharmacy Phone Number

I certify that the information provided by me is true, correct and complete to the best of my knowledge. I authorize my insurance company, TELUS Health (a service provider of my insurance company), their authorized representatives, agents and service providers to use and exchange this information needed for underwriting, administration and paying claims with any person or organization who has relevant information pertaining to this claim including health professionals, institutions and investigative agencies in the event of an audit. I authorize my insurance company and/or TELUS Health (a service provider of my insurance company) to contact any licensed physician, institution, pharmacy or person who has any records or knowledge of me or my health with respect to this submitted claim.

SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN \_\_\_\_\_

Date: (DD/MMM/YYYY): \_\_ / \_\_ / \_\_\_\_

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**B. Information to be Completed by Prescribing Physician**

Drug Name	Strength	Dose
<b>Votrient (pazopanib)</b>		

**Votrient (pazopanib) will be eligible for reimbursement only if the patient satisfies the conditions listed below and if the patient does not qualify for coverage under any other drug plan or government mandated program.** If the patient is covered under another drug plan or government mandated program, the prior authorization program, as part of your drug benefits, may cover the portion not paid for by the primary plan. If “None of the above criteria” is indicated, the patient will not be eligible for reimbursement. **For Quebec plan members, please refer to the RAMQ exception drug criteria, if applicable.**

**Eligibility Criteria**

Please indicate if the patient satisfies the following criteria:

For the treatment of patients (≥18 years old) with metastatic renal cell (clear cell) carcinoma (mRCC) (702392008) as first-line systemic therapy or as second-line systemic therapy after treatment with cytokines for metastatic disease;

OR

For the treatment of patients (≥18 years old) with selective subtypes of advanced Soft Tissue Sarcoma (STS) (424952003) who have received prior chemotherapy for metastatic disease or who have progressed within 12 months after (neo)adjuvant therapy. Patients are required to have disease progression on or after, or be intolerant to, an anthracycline-based regimen.

OR

None of the above criteria applies.

Relevant additional information \_\_\_\_\_

**Physician Information**

Physician's Name	License Number	Telephone Number	Fax Number	
Address	City	Province	Postal Code	
Physician's Signature		Date: (DD/MMM/YYYY) ____ / ____ / ____		