



**Votrient® Prior Authorization Request Form**

**Please fax the completed request form to Mercy Health Plans Pharmacy Department at 314-214-8201 or 800-647-2240. For additional information please call 314-214-8282 or 800-647-2240.**

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Patient Pharmacy ID: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(located on bottom right of insurance card)  
Requesting Physician: \_\_\_\_\_ Specialty: \_\_\_\_\_  
(Please print)  
Office Contact Person: \_\_\_\_\_ Phone #: (\_\_\_\_)\_\_\_\_-\_\_\_\_ ext \_\_\_\_  
Office Address: \_\_\_\_\_  
Medication/dose Requested: \_\_\_\_\_ Fax #: (\_\_\_\_)\_\_\_\_-\_\_\_\_  
Expected Duration of Therapy: \_\_\_\_\_ ICD-9: \_\_\_\_\_

Please circle YES or NO:

1. Does the patient have a diagnosis of advanced renal cell carcinoma?	YES	NO
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**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**For Mercy Health Plans use only:**

Approved Length of Approval \_\_\_\_\_

Denied Reason for Denial \_\_\_\_\_

Reviewer's Signature: \_\_\_\_\_ Date Reviewed: \_\_\_\_/\_\_\_\_/\_\_\_\_

Override Entered in  Caremark  CCMS for \_\_\_\_\_ - \_\_\_\_\_ by \_\_\_\_\_

Office Notified on \_\_\_\_\_; at \_\_\_\_\_ am/pm; by \_\_\_\_\_ spoke to \_\_\_\_\_