OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare
Fotivda® (Tivozanib) Prior Authorization Form

Member Name:_____ ***Date of Birth:***_____ ***Member ID#:***_____

Drug Information

Pharmacy billing (NDC:_____***) Start Date (or date of next dose):***_____

Dose:_____ ***Regimen:***_____

Billing Provider Information

Pharmacy NPI:_____ ***Pharmacy Name:***_____

Pharmacy Phone:_____ ***Pharmacy Fax:***_____

Prescriber Information

Prescriber NPI:_____ ***Prescriber Name:***_____

Prescriber Phone:_____ ***Prescriber Fax:***_____ ***Specialty:***_____

Criteria

For Initial Authorization

1. **Please indicate the diagnosis and information:**
   - ❑ **Renal Cell Carcinoma (RCC)**
     - A. Is diagnosis relapsed or refractory advanced RCC? Yes____ No____
     - B. Has the member received at least 2 prior systemic therapies? Yes___ No____
     - C. Will tivozanib be used in as a single agent? Yes____ No____
   - ❑ **If diagnosis is not listed above, please indicate diagnosis:**_____

Additional Information:_____

_____

For Continued Authorization:

1. Date of last dose:_____
2. Does member have any evidence of progressive disease while on tivozanib?
   Yes____ No____
3. Has the member experienced adverse drug reactions related to tivozanib therapy?
   Yes____ No____

*If yes, please specify adverse reactions:*_____

_____

Prescriber Signature:_____ **Date:**_____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit

Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

CONFIDENTIALITY NOTICE