

Request Form for (pazopanib [Votrient®])

Physician Information

Name: _____

License: _____ Physician specialty: _____

Address: _____

Telephone: _____ Fax: _____

Patient Information

General Information

Name: _____ Date of Birth: _____

Sex: M F Weight (kg): _____ Member ID: _____

Address: _____

Medical Information

1) The patient presents the following diagnosis:

2) If the patient presents renal cell carcinoma:

a. Please provide previous / current therapy:

Drug _____ Date _____

Drug _____ Date _____

b. Does the patient present disease relapse?

Yes NO

c. Which is the renal cell carcinoma stage?

I II III IV

d. Does the patient present medically or surgically unresectable disease?

Yes NO

e. Did the disease progress despite cytokine therapy?

Yes NO

Please provide any medical information which may support approval: (optional)

Physician signature: _____

Date _____