



DATE _____
CLIENT _____

PRIOR AUTHORIZATION QUESTIONNAIRE - Sutent® (sunitinib)

M.D. Last Name: _____	M.D. First Name: _____
Physician Phone: _____	Physician Fax: _____
Patient _____	ID# _____ DOB _____

TO ENSURE PROMPT PROCESSING PLEASE COMPLETE ALL OF THE QUESTIONS.

PLEASE NOTE: FOR ALL REQUESTS, PLEASE ATTACH THE MOST RECENT COPY OF THE PATIENT'S PROGRESS NOTES

PA CRITERIA FOR APPROVAL

1. Please indicate patient's diagnosis:

- Gastrointestinal Stromal Tumor (GIST) (skip to #2)
- Metastatic renal cell carcinoma (MRCC) (skip to #3)
- *Other diagnosis: _____

***Note: If Other diagnosis is used, please attach a study with efficacy data supporting this request**

- | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| 2. Did the patient experience an intolerance to imatinib (Gleevec)/disease progression? | Yes | No |
| 3. Has the patient presented with a cardiac event within the past 12 months? | Yes | No |
| 4. Please provide dosage of Sutent _____ | | |
| 5. If this is a renewal: Has the patient demonstrated disease regression or improvement in health-related quality of life in the past 3 months? (Please provide progress notes) | Yes | No |
| 6. Is the patient hypertensive or have they developed severe hypertension while using Sutent? | Yes | No |
| 7. Please provide starting LVEF _____ Current LVEF _____ | | |
| 8. Is the prescribing physician an oncologist? | Yes | No |

Physician Signature or name of person providing answers _____

Physician Comments _____

Send or Fax completed form to:
877-329-7279

RESTAT
P.O. BOX 758
WEST BEND, WI 53095

QUESTIONS PLEASE CALL:
877-526-9906

www.restat.com

Initial approval will be for a 3 month period. If patient has demonstrated a response to therapy within this time frame, an additional 3 months will be authorized.