

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
SUTENT (sunitinib maleate)

Patient name: _____ Medicaid ID #: _____
Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____
Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____
Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____
Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL
NECESSITY TO 855-828-4992**

CRITERIA:

- Minimum age requirement: 18 years old.
- Documentation of advanced renal cell carcinoma, OR
- Documentation of gastrointestinal stromal tumor for patients who have had disease progression on or are intolerant to Gleevec.

INFORMATION:

Dosing: 50mg daily, 4 weeks on and 2 weeks off. Dose increase or reduction is in 12.5mg increments.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Updated letter or progress note showing improvement or maintenance on Sutent.

9/20/10

<https://medicaid.utah.gov/pharmacy/>