

Health New England
Medication Request Form (MRF)/Prescription Request
Nexavar[®] (sorafenib tosylate)

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

Prior Authorization

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

Instructions:

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Nexavar[®] (sorafenib tosylate). Please complete this form and fax to ICORE Healthcare at **(800)-349-5058**. If you have any questions regarding this process, please contact ICORE Healthcare at **(800) 350-8119**.

Medication Request Information (please complete each section of this form prior to transmittal):

Patient Information (all required)	Physician Information (all required)
Patient Name:	Physician Name:
Patient Cell Phone #: () - 	Specialty:
Patient HNE ID#:	NPI #:
Patient Date of Birth:	HNE Provider #:
Allergies:	DEA #:
	Telephone #: () -
	Fax # (required): () -

Drug Information		
Requested Drug/Strength/Form: Nexavar[®] (sorafenib tosylate) <i>note: HNE allows maximum of 120 tabs per month</i>		
Dose, Directions, and length of treatment (please be specific):	Quantity (per month)	Refills:
Physician Signature:	Date:	

Please Check All That Apply:

- The prescribing physician is a hematologist or oncologist
- Diagnosis is advanced renal cancer cancer
- Diagnosis is unresectable hepatocellular carcinoma
- Diagnosis is _____(please specify)