APPLIES TO COMMERCIAL AND MEDICAID

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

Drug Information		
Requested Drug/Strength/Form: Nexavar ® (sorafenib tosylate) *note: HNE allows maximum of 120 tabs per month*		
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)

Effective date: 5/1/2006 (date of last review 5/11/2010)

© 2006, 2010 Health New England, Inc.