

Health New England
Medication Request Form (MRF)/Prescription Request
Sutent[®] (sunitinib malate)

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 Sutent[®] (sunitinib malate). 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: Sutent[®] (sunitinib malate)		
* Note: HNE allows maximum of 30 tabs per month		
Dose, Directions, and length of treatment (please be specific):	Quantity per month:	Refills:
Physician Signature:		Date:
Please Check All That Apply:		
<input type="checkbox"/> The therapy being initiated by a hematologist or oncologist <input type="checkbox"/> Diagnosis is Advanced Renal Cancer <input type="checkbox"/> Diagnosis is GIST (Gastro Intestinal Stromal Tumor) <input type="checkbox"/> Gleevec has failed <input type="checkbox"/> Diagnosis is _____(please specify or attach references)		