



Nexavar
(sorafenib)
Prior Authorization Form

Express Scripts
Phone 800-417-8164
Fax 877-837-5922

Last Name		First Name		Prescriber's Name		Specialty	
Home Phone		Work Phone		Office Phone		Office Fax	
Home Address		City	State	ZIP	Address		City State ZIP
SCAN ID number		Date of Birth		Est. Start Date		Office Contact	
For Specialty Medications Only: Shipping Address (if different from home address) <input type="checkbox"/> Physician <input type="checkbox"/> Home				Special Instructions (i.e. Non-English Speaking Patient, etc.):			

Medication:		Diagnosis:	
Sig:	Qty:	Refills:	ICD 9 Code:

Secondary/ Supplemental Insurance Company	Phone	Name of Insured	ID Number	Group Number
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<p>1. Does the patient have a diagnosis of one of the following:</p> <ul style="list-style-type: none"> <input type="radio"/> advanced renal cell carcinoma <input type="radio"/> unresectable hepatocellular carcinoma (HCC)
<p>2. Is the prescription originally written or recommended by an Oncologist?</p>
<p>3. Are there any other comments, diagnoses, symptoms, and/or any other information the caller feels is important to this review?</p>

Physician's Signature: _____ NPI/DEA #: _____ Date: _____

<u>For Internal Use Only</u>	
<input type="checkbox"/> Approved	<input type="checkbox"/> Denied
Reviewer's Initials _____	Decision Date _____
Comments _____	