

## Physician Request Form Nexavar®

Fax to Keystone Mercy Pharmacy Services at **215-937-5018**, or to speak to a representative call **800-588-6767**. Form must be completed for processing.

Patient Name: \_\_\_\_\_

Keystone Mercy ID#: \_\_\_\_\_

Address: \_\_\_\_\_

Apt # or Suite #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs = \_\_\_\_\_ Kg

Birth Date: \_\_\_\_\_

Physician Name: \_\_\_\_\_

NPI #: \_\_\_\_\_

Address: \_\_\_\_\_

Apt # or Suite #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

ICD-9 Diagnosis Code: \_\_\_\_\_

Sig (How Administered): \_\_\_\_\_

### SELECT APPROPRIATE DIAGNOSES SECTION:

A. Renal Cell Carcinoma (RCC):

- Tumor Stage \_\_\_\_\_
- Has the tumor been resected? YES/When \_\_\_\_\_  
NO, then why \_\_\_\_\_
- Has the patient repleted after prior surgical intervention? (please check)  Yes  No
- Histology of tumor \_\_\_\_\_
- Other treatments tried/failed \_\_\_\_\_

B. Hepatocellular Carcinoma (HCC)

- Child-Pugh Classification \_\_\_\_\_
- Is the patient a suitable candidate for liver transplantation? (please check)  Yes  No
- Is the patient Hepatitis B surface antigen positive? (please check)  Yes  No
- Does the patient have a nonmetastatic tumor/disease? (please check)  Yes  No
- Has the tumor been resected? YES/When \_\_\_\_\_  
NO, then why \_\_\_\_\_
- Alpha-fetoprotein level: \_\_\_\_\_ ng/ml Date of lab: \_\_\_\_\_

C. Diagnosis other than Renal Cell Carcinoma or Hepatocellular Carcinoma

- Rationale for choosing this treatment, please include all applicable documentation  
\_\_\_\_\_  
\_\_\_\_\_  
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