Physician Request Form Sutent®

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.*

KEYSTONE MERCY HEALTH PLAN
A Program of Keystone First and Mercy Health Plan

Patient Name: _____ Keystone Mercy ID#: _____

Address: _____ Apt # or Suite #: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Height: _____ Weight: _____lbs = _____Kg Birth Date: _____

Physician Name: _____ License #: _____

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):
- o Tumor Stage_____
- o Has the tumor been resected? YES/When_____

  NO, then why_____
- o Has the patient replased after prior surgical intervention? (please check) ❑ Yes ❑ No
- o Histology of tumor_____
- o Other treatments tried/failed_____

❑ B. Gastrointestional Stromal Tumor (GIST)
- o Does the patient have an unresectable or metastatic malignant GIST? (please check) ❑ Yes ❑ No
- o Has the patient tried/failed Gleevec® (inatinib) therapy? (please check) ❑ Yes (then at what dose and start/end date of therapy)

  _____

  ❑ No, then why_____
  _____
  _____

❑ C. Diagnosis other than Renal Cell Carcinoma or Gastrointestinal Stromal Tumor (GIST)
- o Rationale for choosing this treatment, please include all applicable documentation

_____
_____
_____
_____

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