CVS CAREMARK

Fax Referral To: 800-323-2445

Phone: 866-278-6634

Nexavar® (sorafenib)
Enrollment Form
For Blue Cross Blue Shield of Rhode Island Members

Date: _____ **Needs by Date (Please Specify):** _____

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other:** _____

PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
SS #: _____
Insurance ID: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____
Contact Phone: _____

INSURANCE INFORMATION *(If available, please copy and attach the front and back of insurance and prescription drug card)*

Primary Insurance: Subscriber: _____ Subscriber ID#: _____ Name of Insurer: **Blue Cross Blue Shield of RI**

Secondary Insurance: Subscriber: _____ Subscriber ID#: _____ Name of Insurer: _____

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Diagnosis: ☐ 189.0 Renal cell carcinoma ☐ Other: _____ • Date of Diagnosis: _____

APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

- Has the patient been diagnosed with Renal Cell Carcinoma? **OR** ☐ Yes ☐ No
- Has the patient been diagnosed with Kidney Cancer? ☐ Yes ☐ No

Note: The following compendia, American Hospital Formulary Service, U.S. Pharmacopeia Dispensing Information, National Comprehensive Cancer Network NCCN), and Drug & Biologics Compendium™ Category of Evidence and Consensus are considered during prior authorization review if the drug is being prescribed for a condition not listed above. Additional information may be requested if documentation in the compendia is lacking.

Medical Necessity (please attach all supporting documentation):

_____

_____

_____

_____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Nexavar® (sorafenib)	☐ 200mg	☐ Take two tablets (400mg) by mouth twice a day at least one hour before or two hours after eating ☐ _____		

_____ _____

PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)