Nexavar® (sorafenib)
Prior Authorization Form

ROCKY MOUNTAIN HEALTH PLANS®
We understand Colorado. We understand you.

Complete Patient and Physician information (PLEASE PRINT)

STEP 1

Member Name:	Physician Name:
Address:	Address:
Member ID:	Phone #:
Member DOB:	Fax #:
	Tax ID or NPI #:

If Applicable: Pharmacy Name: ____
Pharmacy Phone: ____

STEP 2

Complete the Clinical Assessment:

Diagnosis	☐ Advanced Renal Cell Carcinoma ☐ Unresectable Hepatocellular Carcinoma	☐ Other (please state):
Physician Specialty	☐ Oncology	☐ Other (please state):
Supporting Documentation	Diagnosis: ICD-9 Code #/ Description / J Code (required):	
	Please attach a copy of the prescription or provide ALL of the information below: Nexavar® (sorafenib) Strength ____________ Sig ____________ Qty ____________ Refills ____________	
	Please attach all relevant medical records and test results. **Incomplete forms will not be processed.**	

STEP 3

I certify that the above is correct and accurate to the best of my knowledge (please sign and date).

______________________________ ______________________
Prescriber Signature Date

STEP 4

Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk:

970-248-5034

Name of Person filling out form: ____

Pharmacy Technician initials ______ Date Initiated ____________________

Confidentiality Notice:

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