Physician's Prior Authorization Questionnaire
Nexavar®

Patient: **ID#:** **DOB:**

Patient Address:

Nexavar® is covered under certain clinical conditions. Please furnish the information below to assist us in making a determination of this patient's eligibility for coverage for treatment with this drug.

1. What is the patient's diagnosis? (*Please do not use codes.*) ______________________________

   ____

2. Has the tumor recurred after surgery? ☐ Yes ☐ No

3. Will other forms of chemotherapy be used while on Nexavar®? ☐ Yes ☐ No

   If Yes, please list: ____

Nexavar® will be shipped to the patient from our Specialty Pharmacy.

______________________________	______________________________
Physician's Signature	Date
Please **Print** Physician's Name & Specialty	Phone Number / Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.usableadmin.com/providers/PharmacyForms.aspx