

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
NEXAVAR (sorafenib)

Patient name: _____ Medicaid ID #: _____
Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____
Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____
Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____
Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES AND LETTER OF MEDICAL
NECESSITY TO 855-828-4992 note the new fax number**

CRITERIA:

- Patient must be age 18 or above
- Diagnosis of advanced Renal Cell Carcinoma, OR
- Diagnosis of unresectable Hepatocellular Carcinoma

AUTHORIZATION:

1 year at a maximum dose of 400mg BID.

RE-AUTHORIZATION:

Reauthorization for 1 year via an updated letter of medical necessity

9/15/10

<http://health.utah.gov/medicaid/pharmacy>