

**Health New England**  
**Medication Request Form (MRF)/Prescription Request**  
**Sutent<sup>®</sup> (sunitinib malate)**

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

**Prior Authorization**

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

**Instructions:**

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Sutent<sup>®</sup> (sunitinib malate). Please complete this form and fax to ICORE Healthcare at **(800)-349-5058**. If you have any questions regarding this process, please contact ICORE Healthcare at **(800) 350-8119**.

**Medication Request Information (please complete each section of this form prior to transmittal):**

Patient Information (all required)	Physician Information (all required)
<b>Patient Name :</b>	<b>Physician Name:</b>
<b>Patient Cell Phone #: (     )     -     </b>	<b>Specialty:</b>
<b>Patient HNE ID#:</b>	<b>NPI #:</b>
<b>Patient Date of Birth:</b>	<b>HNE Provider # :</b>
<b>Allergies:</b>	<b>DEA #:</b>
	<b>Telephone #: (     )     -     </b>
	<b>Fax # (required): (     )     -     </b>

Drug Information		
<b>Requested Drug/Strength/Form: Sutent<sup>®</sup> (sunitinib malate)</b>		
* Note: HNE allows maximum of 30 tabs per month		
<b>Dose, Directions, and length of treatment (please be specific):</b>	<b>Quantity per month:</b>	<b>Refills:</b>
<b>Physician Signature:</b>		<b>Date:</b>
<b>Please Check All That Apply:</b>		
<input type="checkbox"/> The therapy being initiated by a hematologist or oncologist <input type="checkbox"/> Diagnosis is Advanced Renal Cancer <input type="checkbox"/> Diagnosis is GIST (Gastro Intestinal Stromal Tumor) <input type="checkbox"/> Gleevec has failed <input type="checkbox"/> Diagnosis is _____(please specify or attach references)		