



DATE _____

CLIENT _____

PRIOR AUTHORIZATION QUESTIONNAIRE - Nexavar® (sorafenib)

M.D. Last Name: _____	M.D. First Name: _____
Physician Phone: _____	Physician Fax: _____
Patient _____	ID# _____ DOB _____

TO ENSURE PROMPT PROCESSING PLEASE COMPLETE ALL OF THE QUESTIONS.

PLEASE NOTE: FOR ALL REQUESTS, PLEASE ATTACH THE MOST RECENT COPY OF THE PATIENT'S PROGRESS NOTES

1. Please check the patient's diagnosis:
- Unresectable hepatocellular carcinoma
 - Advanced renal cell carcinoma
 - Other

If the diagnosis is OTHER, list the diagnosis: _____
Please attach a study showing safety and efficacy data to support the use of Nexavar for this diagnosis.

- | | | |
|---|-----|----|
| 2. If this is a renewal: Has the patient demonstrated disease regression or improvement in health-related quality of life in the past 3 months? | Yes | No |
| 3. Does the patient have a known hypersensitivity to Nexavar® or any of its components? | Yes | No |
| 4. If female, is the patient pregnant or planning to become pregnant? | Yes | No |
| 5. If female, has the patient been advised to not breast feed? | Yes | No |
| 6. If the patient is of child-bearing age, and whether male or female, have they received consultation Regarding the need to use effective birth control for at least 2 weeks after stopping Nexavar? | Yes | No |

Physician Signature or name of person providing answers _____

Physician Comments _____

Send or Fax completed form to:
877-329-7279

RESTAT
P.O. BOX 758
WEST BEND, WI 53095

QUESTIONS PLEASE CALL:
877-526-9906

www.restat.com

Initial approval will be for a 3 month period. If patient has demonstrated a response to therapy within this time frame, an additional 3 months will be authorized.