

Physician Request Form Sutent®

Please return this form to:
AmeriHealth Mercy Health Plan
200 Stevens Drive
Philadelphia, PA 19113

Or fax this form to:
1-877-693-8280 (Standard)
1-877-693-8476 (Urgent Request)
Form must be completed for processing.



Patient Name: _____

Passport ID#: _____

Address: _____

Apt # or Suite #: _____

City: _____ State: _____

Zip Code: _____

Phone #: _____ Height: _____ Weight: _____ lbs = _____ Kg

Birth Date: _____

Physician Name: _____

NPI #: _____

Address: _____

Apt # or Suite #: _____

City: _____ State: _____

Zip Code: _____

Contact Person: _____ Phone #: _____

Fax #: _____

Physician Signature: _____

Date: _____

Diagnosis: _____

ICD-9 Diagnosis Code: _____

Sig (How Administered): _____

SELECT APPROPRIATE DIAGNOSES SECTION:

A. Renal Cell Carcinoma (RCC):

- Tumor Stage _____
- Has the tumor been resected? YES/When _____
- NO, then why _____
- Has the patient replased after prior surgical intervention? (please check) Yes No
- Histology of tumor _____
- Other treatments tried/failed _____

B. Gastrointestinal Stromal Tumor (GIST)

- Does the patient have an unresectable or metastatic malignant GIST? (please check) Yes No
- Has the patient tried/failed Gleevec® (inatinib) therapy? (please check) Yes (then at what dose and start/end date of therapy) _____
- No, then why _____

C. Diagnosis other than Renal Cell Carcinoma or Gastrointestinal Stromal Tumor (GIST)

- Rationale for choosing this treatment, please include all applicable documentation _____
- _____
- _____
- _____