



**Afinitor & Afinitor Disperz (Everolimus)
Prior Authorization Request Form**



Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

URGENT

MEMBER INFORMATION		
LAST NAME:	FIRST NAME:	
PHONE NUMBER:	DATE OF BIRTH:	
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
PATIENT INSURANCE ID NUMBER:		

MALE FEMALE HEIGHT (IN/CM): _____ WEIGHT (LB/KG): _____ ALLERGIES: _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: [HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI DISCLOSURE AUTHORIZATION.PDF](https://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF)

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
 AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION		
LAST NAME:	FIRST NAME:	
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:	
NPI NUMBER:	DEA NUMBER:	
PHONE NUMBER:	FAX NUMBER:	
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:	

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.





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MEMBER'S LAST NAME: _____ MEMBER'S FIRST NAME: _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES:		ICD-10:
<input type="checkbox"/> Advanced neuroendocrine tumors of pancreatic origin* <input type="checkbox"/> Advanced renal cell carcinoma* <input type="checkbox"/> Renal angiomyolipoma with tuberous sclerosis complex (TSC)* <input type="checkbox"/> Subependymal giant cell astrocytoma (SEGA)* <input type="checkbox"/> Tuberous sclerosis complex (TSC) associated partial-onset seizures* <input type="checkbox"/> Other diagnosis*: _____ ICD-10 Code(s): _____ *Please provide documentation.		
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.		
<p>For advanced neuroendocrine tumors of pancreatic origin, answer the following: Is the tumor unresectable, locally advanced or metastatic? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>For advanced renal cell carcinoma, answer the following: Does the patient have a diagnosis of advanced renal cell carcinoma defined as greater than or equal to stage T3a based on the American Society System?* <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient tried and failed Nexavar, Sutent, or Votrient?* <input type="checkbox"/> Yes <input type="checkbox"/> No *Please provide documentation.</p> <p>For renal angiomyolipoma with tuberous sclerosis complex (TSC), answer the following: Does the patient have documented tuberous sclerosis and renal angiomyolipoma(s) greater than or equal to 3 cm in length?* <input type="checkbox"/> Yes <input type="checkbox"/> No *Please provide documentation.</p> <p>For renal angiomyolipoma with tuberous sclerosis complex (TSC), answer the following: Does the patient have documented tuberous sclerosis and renal angiomyolipoma(s) greater than or equal to 3 cm in length?* <input type="checkbox"/> Yes <input type="checkbox"/> No *Please provide documentation.</p> <p>REAUTHORIZATION FOR RENAL ANGIOMYOLIPOMA WITH TUBEROUS SCLEROSIS COMPLEX (TSC): Have there been any new developments of angiomyolipoma lesions that are greater than or equal to 1cm? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient's angiomyolipoma volume decreased by $\geq 50\%$ since initiating Afinitor therapy?* <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient's kidney volume increased by more than 20%?* <input type="checkbox"/> Yes <input type="checkbox"/> No Has there been any angiomyolipoma related bleeding greater than or equal to Grade 2?* <input type="checkbox"/> Yes <input type="checkbox"/> No *Please provide documentation.</p> <p>For subependymal giant cell astrocytoma (SEGA), answer the following:</p>		





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Is SEGA associated with tuberous sclerosis (TS)?* Yes No

**Please provide documentation.*

Is the patient a candidate for curative surgical resection? Yes No

For tuberous sclerosis complex (TSC) associated partial-onset seizures, answer the following:

Does the patient have a confirmed diagnosis of tuberous sclerosis complex with treatment-resistant epilepsy?

Yes No

Does the patient currently take up to three other antiepileptic agents, as corroborated in submitted chart notes?*

Yes No

**Please prove documentation (i.e., chart notes).*

Will Afinitor/Afinitor Disperz be used as a single-agent anti-epileptic therapy? Yes No

Has the patient had an episode of status epilepticus within the past 12 months? Yes No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

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FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.

4801 E. Washington Street, Phoenix, AZ 85034

Phone: 877-228-7909

