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

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:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	**DURATION OF THERAPY** (SPECIFY DATES):	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Advanced neuroendocrine tumors of pancreatic origin* ☐ Advanced renal cell carcinoma* ☐ Renal angiomyolipoma with tuberous sclerosis complex (TSC)* ☐ Subependymal giant cell astrocytoma (SEGA)* ☐ Tuberous sclerosis complex (TSC) associated partial-onset seizures* ☐ Other diagnosis*: _____ ICD-10 Code(s): _____ ***Please provide documentation.**	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Is this drug being prescribed to this patient as part of a treatment regimen specified within a sponsored clinical trial? ☐ Yes ☐ No

<u>For initial requests</u>, please answer the following:

For <u>advanced neuroendocrine tumors of pancreatic origin</u>, answer the following:
Is the tumor unresectable, locally advanced or metastatic? ☐ Yes ☐ No

For <u>advanced renal cell carcinoma</u>, answer the following:
Does the patient have a diagnosis of advanced renal cell carcinoma defined as greater than or equal to stage T 3a based on the American Society System?* ☐ Yes ☐ No
Has the patient tried and failed Nexavar, Sutent, or Votrient?* ☐ Yes ☐ No
Please provide documentation.

For <u>renal angiomyolipoma with tuberous sclerosis complex (TSC)</u>, answer the following:
Does the patient have documented tuberous sclerosis and renal angiomyolipoma(s) greater than or equal to 3 cm in length?* ☐ Yes ☐ No
Please provide documentation.

For <u>subependymal giant cell astrocytoma (SEGA),</u> answer the following:
Is SEGA associated with tuberous sclerosis (TS)?* ☐ Yes ☐ No
***Please provide documentation*.**

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

For <u>tuberous sclerosis complex (TSC) associated partial-onset seizures</u>, answer the following:
Does the patient have a confirmed diagnosis of tuberous sclerosis complex with treatment-resistant epilepsy?
☐ Yes ☐ No

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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**

Renewal requests, please answer the following:

For advanced neuroendocrine tumors of pancreatic origin, answer the following:
Is patient continuing to respond to therapy? □ **Yes** □ **No** ***Please provide documentation.***

For advanced renal cell carcinoma, answer the following:
Is patient continuing to respond to therapy? □ **Yes** □ **No** ***Please provide documentation.***

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?
□ **Yes** □ **No**
Has the patient's angiomyolipoma volume decreased by ≥ 50% since initiating Afinitor therapy?* □ **Yes** □ **No**
Has the patient's kidney volume increased by more than 20%?* □ **Yes** □ **No**
Has there been any angiomyolipoma related bleeding greater than or equal to Grade 2?* □ **Yes** □ **No**
Please provide documentation.

For subependymal giant cell astrocytoma (SEGA), answer the following:
Is patient continuing to respond to therapy? □ **Yes** □ **No** ***Please provide documentation.***

For tuberous sclerosis complex (TSC) associated partial-onset seizures, answer the following:
Is patient continuing to respond to therapy? □ **Yes** □ **No** ***Please provide documentation.***

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

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

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