PEHP Health & Benefits

Afinitor® (everolimus)

PRIOR AUTHORIZATION REQUEST FORM

For authorization, **please answer each question, include patient chart notes to document clinical information, and fax this form back to the PEHP Prior Authorization Department at (801) 245-7774** or mail to: PEHP Pharmacy services, 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization questions, you may phone the PEHP Customer Service at (801) 366-7551.

1. Date:	2. Patient Name:	3. ID #:
4. D.O.B:	5. Physician:	6. Office Phone:
7. Office Fax:	8. Office Contact:	9. Dose Request:
10. Sex:	11. Weight:	

Authorization is requested from: to

Not to exceed 3 months for initial therapy. Additional therapy may be approved for up to 1 year.

Question	Yes	No	Comments/Notes
12. Is the prescribing provider a board-certified oncologist or nephrologist?			
13. Please indicate patient's diagnosis: ☐ Advanced Renal Cell Carcinoma ☐ Advanced Breast Cancer ☐ Subependymal Giant Cell Astrocytoma Associated with Tuberous Sclerosis ☐ Renal Angiomyolipoma and Tuberous Sclerosis Complex ☐ Progressive Neuroendocrine Tumors of Pancreatic Origin ☐ Other*: _____			*Please include clinical studies or articles to support this use of Afinitor®.
14. Is the diagnosis documented as **Advanced Renal Cell Carcinoma**?			If 'no' skip to 18.
15. Is the carcinoma surgically unresectable?			
16. Has the patient tried and failed Sutent® (sunitinib) or Nexavar® (sorafenib)?			Verification will be made by reviewing the patient's drug history.
17. Will the patient be receiving Afinitor® in combination with interferon alfa, interleukin-2 therapy, Sutent®, or Nexavar®?			Verification will be made by reviewing the patient's drug history.
18. Is the diagnosis documented as **Advanced Neuroendocrine Tumors of Pancreatic Origin**?			If 'no' skip to 22.
19. Is the tumor unresectable, locally advanced or metastatic?			
20. Will Afinitor® be used to treat carcinoid tumors?			
21. Has the disease advanced within the last 12 months and the patient has an ECOG performance status 0, 1, or a Karnofsky equivalent 80-100?			
22. Is the diagnosis documented as **Subepyndymal Giant Cell Astrocytoma Associated with Tuberous sclerosis?**			If 'no' skip to 25.
23. Is curative resection an option?			
24. Is the patient's BSA ≥ 0.5 m^2?			
25. Is the diagnosis documented as **Renal Angiomyolipoma and Tuberous Sclerosis Complex**?			If 'no' skip to 28.
26. Has the patient had at least one angiomyolipoma of >3cm in longest diameter on CT/MRI?			
27. Does the patient have an active angiomyolipoma related bleeding?			
28. Is the diagnosis documented as **Advanced Breast Cancer**?			
29. Is the tumor estrogen receptor positive and HER2 negative			
30. Has the patient experienced disease progression despite the use of anastrozole or letrozole?			Verification will be made by reviewing the patient's drug history.
31. Is the patient a postmenopausal female?			
32. Has the patient ever received exemestane?			
33. Will the patient receive Afinitor® in combination with exemestane?			
34. If the patient has had previous treatment with Afinitor® and you are requesting re-authorization, has the patient experienced **NO** disease progression?			Documentation or imaging must be provided.

35. Physician's Signature: _____