



Please complete ALL information below and fax your request to 1-888-671-5285

Afinitor® & Afinitor® Disperz™ Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if generic substitution is acceptable			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
Select the diagnosis below: <input type="checkbox"/> Advanced neuroendocrine tumors of pancreatic origin (pNET) <input type="checkbox"/> Advanced renal cell carcinoma (RCC) <input type="checkbox"/> Breast cancer <input type="checkbox"/> Neuroendocrine tumors of gastrointestinal or lung origin <input type="checkbox"/> Renal angiomyolipoma with tuberous sclerosis complex (TSC) <input type="checkbox"/> Subependymal giant cell astrocytoma (SEGA) associated with tuberous sclerosis (TS) <input type="checkbox"/> Tuberous sclerosis complex (TSC)-associated partial-onset seizures <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Prescriber's Specialty: Select if Afinitor is prescribed by or in consultation with one of the following: <input type="checkbox"/> Oncologist <input type="checkbox"/> Nephrologist <input type="checkbox"/> Neurologist					
For advanced neuroendocrine tumors of pancreatic origin (pNET), answer the following: Does the patient have progressive pNET? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have unresectable, locally advanced disease? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have metastatic disease? <input type="checkbox"/> Yes <input type="checkbox"/> No					
For advanced renal cell carcinoma (RCC), answer the following: Does the patient have advanced/metastatic RCC? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had trial and failure with Sutent (sunitinib) or Nexavar (sorafenib)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
For breast cancer, answer the following: Does the patient have advanced disease? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have hormone receptor (HR) positive breast cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have HER-2 negative breast cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had trial and failure, contraindication, or intolerance to Femara (letrozole) or Arimidex (anastrozole)? <input type="checkbox"/> Yes <input type="checkbox"/> No Will Afinitor be used in combination with Aromasin (exemestane)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
For neuroendocrine tumors of gastrointestinal or lung origin, answer the following: Does the patient have progressive, well-differentiated, non-functional neuroendocrine tumors of gastrointestinal or lung origin? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have unresectable, locally advanced disease? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have metastatic disease? <input type="checkbox"/> Yes <input type="checkbox"/> No					

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of FutureScripts. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: Afinitor_FSP_2019Jul-W



Afinitor® & Afinitor® Disperz™ Prior Authorization Request Form (Page 2 of 2)
DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

For renal angiomyolipoma with tuberous sclerosis complex (TSC), answer the following: Does the patient require immediate surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No
For subependymal giant cell astrocytoma (SEGA) associated with tuberous sclerosis, answer the following: Is the patient a candidate for curative surgical resection? <input type="checkbox"/> Yes <input type="checkbox"/> No
For tuberous sclerosis complex (TSC)-associated partial onset seizures, answer the following: Will the requested medication be used as adjunctive therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Reauthorization: For tuberous sclerosis complex (TSC)-associated partial onset seizures, answer the following: Does the patient show reduction in seizure frequency while on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No For all other indications, answer the following: Does the patient show evidence of progressive disease while on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Quantity Limit Requests: What is the quantity requested per DAY? _____ What is the reason for exceeding the plan limitations? <input type="checkbox"/> Titration or loading dose purposes <input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime) <input type="checkbox"/> Requested strength/dose is not commercially available <input type="checkbox"/> Other: _____

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: This request may be denied unless all required information is received.