PRO ACT
PHARMACY BENEFIT MANAGEMENT

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

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

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:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Advanced neuroendocrine tumor of pancreatic origin (pNET)
❑ Advanced renal cell carcinoma (RCC)
❑ Breast cancer
❑ Neuroendocrine tumors of gastrointestinal or lung origin
❑ Renal angiomyolipoma with tuberous sclerosis complex (TSC)
❑ Subependymal giant cell astrocytoma (SEGA) associated with tuberous sclerosis (TS)
❑ Other diagnosis:_____ICD-10 Code(s): _____

Provider's Specialty:

Select if Afinitor is prescribed by or in consultation with one of the following:
❑ Oncologist
❑ Nephrologist

For advanced neuroendocrine tumor of pancreatic origin (pNET), answer the following:

Does the patient have progressive pNET? ❑ **Yes** ❑ **No**
Does the patient have unresectable, locally advanced disease? ❑ **Yes** ❑ **No**
Does the patient have metastatic disease? ❑ **Yes** ❑ **No**

For advanced renal cell carcinoma (RCC), answer the following:

Does the patient have advanced/metastatic RCC? ❑ **Yes** ❑ **No**
Does the patient have history of failure with Sutent (sunitinib) or Nexavar (sorafenib)? ❑ **Yes** ❑ **No**

For breast cancer, answer the following:

Does the patient have advanced disease? ❑ **Yes** ❑ **No**
Does the patient have hormone receptor (HR) positive breast cancer? ❑ **Yes** ❑ **No**
Does the patient have HER-2 negative breast cancer? ❑ **Yes** ❑ **No**
Does the patient have history of failure, contraindication, or intolerance to Femara (letrozole) or Arimidex (anastrozole)? ❑ **Yes** ❑ **No**
Will Afinitor be used in combination with Aromasin (exemestane)? ❑ **Yes** ❑ **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? ❑ **Yes** ❑ **No**
Does the patient have unresectable, locally advanced disease? ❑ **Yes** ❑ **No**
Does the patient have metastatic disease? ❑ **Yes** ❑ **No**

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For renal angiomyolipoma with tuberous sclerosis complex (TSC), answer the following: Does the patient require immediate surgery? ❑ **Yes** ❑ **No**
For subependymal giant cell astrocytoma (SEGA) associated with tuberous sclerosis, answer the following: Is the patient a candidate for curative resection? ❑ **Yes** ❑ **No**
Reauthorization: **If this is a reauthorization request, answer the following question:** Does the patient show evidence of progressive disease while on therapy? ❑ **Yes** ❑ **No**
Quantity Limit Requests: What is the quantity requested per DAY? _____ **What is the reason for exceeding the plan limitations?** ❑ Titration or loading dose purposes ❑ 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) ❑ Requested strength/dose is not commercially available ❑ Other: _____

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

_____

_____

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

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	