CVS caremark™ {{PANUMCODE}}

Afinitor, Afinitor Disperz [everolimus]

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What drug is being prescribed?
   - ❑ Afinitor 2.5 mg
   - ❑ Afinitor 5 mg
   - ❑ Afinitor 7.5 mg
   - ❑ Afinitor 10 mg
   - ❑ Afinitor Disperz 2 mg
   - ❑ Afinitor Disperz 3 mg
   - ❑ Afinitor Disperz 5 mg
   - ❑ everolimus 2 mg
   - ❑ everolimus 2.5 mg
   - ❑ everolimus 3 mg
   - ❑ everolimus 5 mg
   - ❑ everolimus 7.5 mg
   - ❑ everolimus 10 mg

2. What is the patient's diagnosis?
   - ❑ Breast cancer
   - ❑ Renal cell carcinoma
   - ❑ Neuroendocrine tumors of the pancreas
   - ❑ Neuroendocrine tumors of the lung
   - ❑ Neuroendocrine tumors of the gastrointestinal tract
   - ❑ Neuroendocrine tumors of the thymus
   - ❑ Neuroendocrine tumors, well differentiated Grade 3
   - ❑ Tuberous sclerosis complex (TSC)
   - ❑ Soft tissue sarcoma
   - ❑ Gastrointestinal stromal tumors
   - ❑ Thymoma or thymic carcinoma
   - ❑ Classic Hodgkin lymphoma
   - ❑ Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma
   - ❑ Thyroid carcinoma
   - ❑ Endometrial carcinoma
   - ❑ Glioma (including glioblastoma)
   - ❑ Meningioma
   - ❑ Subependymal giant cell astrocytoma (SEGA)
   - ❑ Erdheim-Chester Disease (ECD)
   - ❑ Rosai-Dorfman Disease
   - ❑ Langerhans Cell Histiocytosis (LCH)
   - ❑ Other _____

3. What is the ICD-10 code? _____

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

4. The preferred product for your patient's health plan is generic everolimus. Can the patient's treatment be switched to the preferred product? ***If Yes, fax a new prescription to the pharmacy and skip to #7.***
   ❑ Yes - everolimus _____ mg
   ❑ No - Continue request for non-preferred medication
   ❑ Not applicable, prescribed drug is everolimus

5. Does the patient have a documented intolerable adverse event to the preferred product, generic everolimus? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No

6. Was the documented intolerable adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information? ***ACTION REQUIRED: If No, attach supporting chart note(s).***
   ❑ Yes ❑ No

7. Is this a request for continuation of therapy with the requested medication?
   ❑ Yes ❑ No *If No, skip to diagnosis section.*

8. Is there evidence of disease progression or an unacceptable toxicity while on the current regimen? ❑ Yes ❑ No

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Breast Cancer

9. Does the patient have recurrent or metastatic disease? ❑ Yes ❑ No

10. What is the tumor's hormone receptor (HR) status? ❑ Positive ❑ Negative ❑ Unknown

11. What is the tumor's human epidermal growth factor receptor-2 (HER2) status?
    ❑ Positive ❑ Negative ❑ Unknown

12. Is the requested medication being prescribed in combination with exemestane, fulvestrant, or tamoxifen?
    ❑ Yes ❑ No

13. Will the requested medication be used as subsequent therapy? ❑ Yes ❑ No

Section B: Renal Cell Carcinoma

14. Does the patient have relapsed, advanced, or stage IV disease? ❑ Yes ❑ No

15. What is the tumor's histology?
    ❑ Clear cell
    ❑ Non-clear cell, *skip to #17*
    ❑ Other or unknown _____

16. Will the requested medication be given as a single agent or in combination with lenvatinib as subsequent therapy?
    ❑ Yes ❑ No *No further questions.*

17. Will the requested medication be given in any of the following regimens?
    ❑ Single agent
    ❑ In combination with lenvatinib
    ❑ In combination with bevacizumab
    ❑ None of the above

Section C: Soft Tissue Sarcoma

18. What is the soft tissue sarcoma subtype?
    ❑ Perivascular epithelioid cell (PEComa)
    ❑ Angiomyolipoma
    ❑ Lymphangioleiomyomatosis
    ❑ Other _____

19. Will the requested medication be given as single agent therapy? ❑ Yes ❑ No

20. *If the soft tissue sarcoma subtype is angiomyolipoma,* does the patient have recurrent disease? ❑ Yes ❑ No

Section D: Gastrointestinal Stromal Tumor

21. Does the patient have unresectable, recurrent, or metastatic disease? ❑ Yes ❑ No

22. Has the patient failed at least four FDA-approved therapies (e.g., imatinib, sunitinib, regorafenib, ripretinib)? ❑ Yes ❑ No

23. Will the requested medication be given in combination with either imatinib, sunitinib, or regorafenib? ❑ Yes ❑ No

Section E: Thymoma or Thymic Carcinoma

24. Will the requested medication be given as a single agent? ❑ Yes ❑ No

Section F: Classic Hodgkin Lymphoma

25. Does the patient have relapsed or refractory disease? ❑ Yes ❑ No

26. Will the requested medication be given as a single agent for third-line or subsequent systemic therapy? ❑ Yes ❑ No

Section G: Waldenstrom's Macroglobulinemia/Lymphoplasmacytic Lymphoma

27. Has the disease been treated previously? ❑ Yes ❑ No

28. Will the requested medication be given as single agent therapy? ❑ Yes ❑ No

Section H: Thyroid Carcinoma

29. What is the tumor's histology?
    - ❑ Papillary
    - ❑ Hurthle cell
    - ❑ Follicular
    - ❑ Medullary
    - ❑ Other _____

30. Does the patient have progressive and/or symptomatic disease, not amenable to radioactive iodine (RAI) therapy? ❑ Yes ❑ No

Section I: Endometrial Carcinoma

31. Will the requested medication be given in combination with letrozole? ❑ Yes ❑ No

Section J: Subependymal Giant Cell Astrocytoma (SEGA)

32. Will the requested medication be given as a single agent for adjuvant treatment? ❑ Yes ❑ No

Section K: Erdheim-Chester Disease (ECD), Rosai-Dorfman Disease

33. Does the patient have symptomatic disease? *If Yes, skip to #35* ❑ Yes ❑ No

34. Does the patient have relapsed or refractory disease? ❑ Yes ❑ No

35. Does the patient's disease have a phosphatidylinositol-4,5-bisphosphate 3-kinase catalytic subunit alpha (PIK3CA) mutation? ***ACTION REQUIRED: If Yes, attach supporting documentation.*** ❑ Yes ❑ No

36. Will the requested medication be used as a single agent? ❑ Yes ❑ No

Section L: Langerhans Cell Histiocytosis (LCH)

37. Does the patient's disease have a phosphatidylinositol-4,5-bisphosphate 3-kinase catalytic subunit alpha (PIK3CA) mutation? ***ACTION REQUIRED: If Yes, attach supporting documentation.*** ❑ Yes ❑ No

38. Will the requested medication be used as a single agent? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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