Afinitor, Afinitor Disperz

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.

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Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. What is the requested drug?
   - ❑ Afinitor
   - ❑ Afinitor Disperz

2. What is the patient's diagnosis?
   - ❑ Breast cancer
   - ❑ Renal cell carcinoma
   - ❑ Progressive pancreatic neuroendocrine tumor
   - ❑ Progressive, well-differentiated, non-functional lung neuroendocrine tumor
   - ❑ Progressive, well-differentiated, non-functional gastrointestinal neuroendocrine tumor
   - ❑ Progressive, well-differentiated, non-functional thymic neuroendocrine tumor
   - ❑ 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)
   - ❑ Other _____

3. What is the ICD-10 code? _____

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

5. Has the patient experienced disease progression or an unacceptable toxicity with the requested medication?
   ❑ Yes ❑ No *No further questions*

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

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

Section A: Breast Cancer

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

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

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

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

10. Has the patient received endocrine therapy (e.g., anastrazole, exemestane, tamoxifen, toremifene, fulvestrant, letrozole) within 1 year? ❑ Yes ❑ No

Section B: Renal Cell Carcinoma

11. Does the patient have relapsed or metastatic disease? ❑ Yes ❑ No

12. What is the tumor's histology?
    ❑ Clear cell
    ❑ Non-clear cell, *skip to #14*
    ❑ Other or unknown _____

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

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

Section C: Progressive Pancreatic Neuroendocrine Tumor and Progressive, Well-Differentiated, Non-Functional Lung, Gastrointestinal, or Thymic Neuroendocrine Tumor

15. Does the patient have unresectable, locally advanced, or metastatic disease? ❑ Yes ❑ No

Section D: Soft Tissue Sarcoma

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

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

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

Section E: Gastrointestinal Stromal Tumor

19. Did the patient experience disease progression after single agent therapy with imatinib, sunitinib, and regorafenib?
    ❑ Yes ❑ No

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

Section F: Thymoma or Thymic Carcinoma

21. Will the requested medication be given as a single agent for second-line therapy? ❑ Yes ❑ No

Section G: Classic Hodgkin Lymphoma

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

23. Will the requested medication be given as a single agent for third-line or subsequent systemic therapy?

❑ Yes ❑ No

Section H: Waldenstrom's Macroglobulinemia/Lymphoplasmacytic Lymphoma

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

25. Does the patient have progressive relapsed disease? *If Yes, no further questions* ❑ Yes ❑ No

26. Did the patient's disease respond to primary therapy previously? ❑ Yes ❑ No

Section I: Thyroid Carcinoma

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

28. Does the patient have progressive and/or symptomatic iodine-refractory disease? ❑ Yes ❑ No

Section J: Endometrial Carcinoma

29. Will the requested medication be given in any of the following regimens?
    - ❑ In combination with letrozole
    - ❑ In combination with letrozole for adjuvant treatment for surgically staged patients
    - ❑ None of the above

Section K: Subependymal Giant Cell Astrocytoma (SEGA)

30. Will the requested medication be given as a single agent for adjuvant treatment? ❑ 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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