

Afinitor
Prior Authorization Request

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

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 patient's diagnosis?

<input type="checkbox"/> Breast cancer (recurrent or metastatic) <input type="checkbox"/> Lung neuroendocrine tumor <input type="checkbox"/> Gastrointestinal neuroendocrine tumor <input type="checkbox"/> Soft tissue sarcoma <input type="checkbox"/> Classical Hodgkin Lymphoma <input type="checkbox"/> Renal angiomyolipoma associated with tuberous sclerosis complex (TSC) <input type="checkbox"/> Subependymal giant cell astrocytoma (SEGA) associated with tuberous sclerosis complex (TSC) <input type="checkbox"/> Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma <input type="checkbox"/> Other _____	<input type="checkbox"/> Renal cell carcinoma (relapsed or unresectable) <input type="checkbox"/> Pancreatic neuroendocrine tumor <input type="checkbox"/> Thymomas and thymic carcinomas <input type="checkbox"/> Osteosarcoma
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2. What is the ICD-10 code? _____

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

Section A: Breast cancer (recurrent or metastatic) _____

3. What is the tumor's hormone receptor (HR) status? Positive Negative Unknown
4. What is the tumor's human epidermal growth factor receptor-2 (HER2) status?
 Positive Negative Unknown
5. What is the prescribed regimen? Afinitor and exemestane Other

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6. Does the patient meet ANY of the following conditions?

Indicate below or mark "None of the above".

- The patient has been previously treated with tamoxifen
- The disease has progressed while on OR within the 12 months of therapy with a nonsteroidal aromatase inhibitor (e.g., Arimidex, Femara)
- None of the above

Section B: Renal cell carcinoma (relapsed or unresectable)

7. What is the tumor's histology?

- Predominantly clear cell
- Predominantly non-clear cell
- Other _____

8. *If patient's tumor histology is predominantly clear cell*, has the disease progressed after previous treatment with antiangiogenic therapy (e.g., Sutent, Nexavar, Avastin, Votrient)? Yes No

9. *If patient's tumor histology is predominantly non-clear cell*, will Afinitor be used as first-line systemic therapy? Yes No

Section C: Soft Tissue Sarcoma

10. What is the soft tissue sarcoma subtype?

- Perivascular epithelioid cell (PEComa)
- Angiomyolipoma
- Lymphangioleiomyomatosis
- Other _____

Section D: Classical Hodgkin Lymphoma

11. Is the disease relapsed or refractory? *If Yes, no further questions* Yes No

12. What is the intent of therapy?

- Palliative therapy
- Other _____

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)