

Member Name: _____ Date of Birth: _____ Member ID#: _____

Drug Information

Pharmacy billing (NDC: _____)
Dose: _____ Regimen: _____ Start Date: _____

Billing Provider Information

Provider NPI: _____ Provider Name: _____
Provider Phone: _____ Provider Fax: _____

Prescriber Information

Prescriber NPI: _____ Provider Name: _____
Prescriber Phone: _____ Prescriber Fax: _____ Specialty: _____

Criteria

Page 1 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.

For Initial Authorization (Initial approval will be for the duration of 6 months for cancer diagnoses and 3 months for seizure diagnosis):

1. Please indicate the diagnosis and information:

- Advanced breast cancer
 - A. Does patient have negative expression of HER2? Yes ___ No ___
 - B. Is patient hormone receptor positive? Yes ___ No ___
 - C. Is everolimus being used in combination with exemestane? Yes ___ No ___
 - D. Has the patient failed treatment with or intolerant to letrozole or anastrozole? Yes ___ No ___
 - E. Does the patient have a contraindication to letrozole or anastrozole? Yes ___ No ___
- Neuroendocrine tumor of pancreatic origin (PNET) or neuroendocrine tumors (NET) of gastrointestinal or lung origin
 - A. Does the patient have unresectable, locally advanced, or metastatic neuroendocrine tumors of pancreatic (PNET), gastrointestinal, or lung (NET) origin? Yes ___ No ___
 - B. Has the patient had progressive disease from a previous treatment? Yes ___ No ___
 - C. Please provide dates/dose/duration of previous treatment: _____

- Advanced renal cell carcinoma
 - A. Has the patient failed treatment with sunitinib or sorafenib? Yes ___ No ___
 - B. Is everolimus being used in combination with lenvatinib? Yes ___ No ___
- Renal angiomyolipoma with tuberous sclerosis complex (TSC)
 - A. Does the patient require immediate surgery? Yes ___ No ___
 - B. Age ≥ 1 year Yes ___ No ___
- Subependymal Giant Cell Astrocytoma (SEGA) with Tuberous Sclerosis Complex (TSC)
 - A. Does the patient require therapeutic intervention, but cannot be curatively resected? Yes ___ No ___
- Tuberous sclerosis complex (TSC)-associated partial-onset seizures
 - A. Is the prescriber a neurologist? Yes ___ No ___
 - B. Has the member failed other medications commonly used for seizures? Yes ___ No ___
If yes, please provide the medications used: _____
 - C. Will everolimus be used as adjunctive therapy? Yes ___ No ___
 - D. Is the member taking any P-gp and strong CYP3A4 inhibitors (e.g., ketoconazole, itraconazole, ritonavir, clarithromycin)? Yes ___ No ___
 - E. Is the member taking St. John's wort? Yes ___ No ___

Page 1 of 2

Please complete and return all pages. Failure to complete all pages will result in processing delays.
Please do not send chart notes. Specific information will be requested if necessary.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit
Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

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State of Oklahoma
Oklahoma Health Care Authority
Afinitor® (Everolimus) Prior Authorization Form

Member Name: _____ Date of Birth: _____ Member ID#: _____

Criteria

Page 2 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.

1. Please indicate the diagnosis and information, continued:

- Tuberos sclerosis complex (TSC)-associated partial-onset seizures (continued)
 - F. Will everolimus trough levels and adverse reactions (e.g., non-infectious pneumonitis, stomatitis, hyperglycemia, dyslipidemia, thrombocytopenia, neutropenia, febrile neutropenia) be monitored, and dosing changes or discontinuations correspond with recommendations in the drug labeling? Yes ___ No ___
 - G. Will female members use contraception while receiving everolimus therapy and for eight weeks after the last dose of everolimus? Yes ___ No ___
 - H. Will male members with female partners of reproductive potential use contraception while receiving everolimus therapy and for four weeks after the last dose of everolimus? Yes ___ No ___
 - I. Member's body surface area (BSA): _____ Date of Measurements: _____
- If answer is none of the above, please indicate diagnosis: _____

For Continued Authorization (cancer diagnosis):

- 1. Does the patient show evidence of progressive disease while on everolimus? Yes ___ No ___
- 2. Has the member experienced any adverse drug reactions related to everolimus therapy? Yes ___ No ___
If yes, please specify adverse reactions: _____

Additional Information: _____

For Continued Authorization [tuberos sclerosis complex (TSC)-associated partial-onset seizures diagnosis]:

- 1. Has the member responded well to treatment with everolimus? Yes ___ No ___

Additional Information: _____

DRAFT

Please complete and return all pages. Failure to complete all pages will result in processing delays.

Prescriber Signature: _____ Date: _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

Please do not send chart notes. Specific information will be requested if necessary.

<p>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</p> <p>University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4</p>	<p>CONFIDENTIALITY NOTICE</p> <p><i>This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.</i></p>
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