SoonerCare
Oklahoma Health Care Authority

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

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

For Initial Authorization (Initial approval will be for the duration of 6 months):

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 ☐
   - ☐ If answer is none of the above, please indicate diagnosis: _____

For Continued Authorization:

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: _____

_____

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 PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
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	*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.*