Afinitor (for Maryland only)

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.

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: _____ **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?
   - ❑ Breast cancer (recurrent or metastatic)
   - ❑ Renal cell carcinoma (relapsed or unresectable)
   - ❑ Lung neuroendocrine tumor
   - ❑ Pancreatic neuroendocrine tumor
   - ❑ Gastrointestinal neuroendocrine tumor
   - ❑ Thymomas and thymic carcinomas
   - ❑ Soft tissue sarcoma
   - ❑ Osteosarcoma
   - ❑ Classical Hodgkin Lymphoma
   - ❑ Renal angiomyolipoma associated with tuberous sclerosis complex (TSC)
   - ❑ Subependymal giant cell astrocytoma (SEGA) associated with tuberous sclerosis complex (TSC)
   - ❑ Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma
   - ❑ Other _____

2. What is the ICD-10 code? _____

3. Would the prescriber like to request an override of the step therapy requirement?
   ❑ Yes ❑ No *If No, skip to diagnosis section*

4. Has the member received the medication through a pharmacy or medical benefit within the past 180 days?
   ACTION REQUIRED: Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e. PBM medication history, pharmacy receipt, EOB etc.) ❑ Yes ❑ No

5. Is the medication effective in treating the member's condition? ❑ Yes ❑ No

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 _____

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)**