

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Afinitor

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name: Supervising Physicia	an·
	1	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address: Address:		
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name	e (if applicable):
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information following qu	n for this patient that mestions and sign.	nay support approval. Please answer the
Q1. What diagnosis is this drug being prescribed for (pick	one)?	
Advanced renal cell carcinoma (RCC)		
☐ Subependymal giant cell astrocytoma (SEGA) associa	ted with tuberous scle	erosis complex (TSC)
☐ Progressive neuroendocrine tumors of pancreatic original	ins (PNET)	
Advanced hormone receptor-positive, HER2-negative	breast cancer	
Renal angiomyolipoma and tuberous sclerosis comple	x (TSC)	
☐ Other		
Q2. Please provide ICD code(s) for diagnosis.		
Q3. Please indicate location of administration.		
☐ Home		
☐ Long Term Care (LTC) facility		
☐ Physician office (drug from office stock - buy and bill)		
☐ Physician office (drug from pharmacy with a prescription	on)	
Q4. If RCC: Has the patient demonstrated disease progre or Nexavar (sorafenib)?	ssion or intolerance fo	ollowing treatment with Sutent (sunitinib)



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Patient Name:	Supervising Physician:		
☐ Yes ☐ No			
Q5. If SEGA: Is the patient a candidate for sugical resection	n?		
☐ Yes ☐ No			
Q6. If PNET: Is the tumor unresectable, locally advanced,	or metastatic?		
☐ Yes ☐ No			
Q7. If breast cancer: Is the patient a postmenopausal woman?			
☐ Yes ☐ No			
Q8. If breast cancer: Is Afinitor being used in combination with exemestane?			
☐ Yes ☐ No			
Q9. If breast cancer: Has the patient failed treatment with I	etrozole or anastrozole?		
☐ Yes ☐ No			
Q10. If renal renal angiomyolipoma: Does the patient require immediate surgery?			
☐ Yes ☐ No			
Q11. Is the prescribing physician an Oncologist?			
☐ Yes ☐ No			
Q12. Additional Comments			
Prescriber Signature	Date		

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function



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Patient Name:	Supervising Physician:

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

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