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 Physician:**	
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 (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. What diagnosis is this drug being prescribed for (pick one)?

- ☐ Advanced hormone receptor-positive, HER2-negative breast cancer
- ☐ Progressive neuroendocrine tumors of pancreatic origins (PNET)
- ☐ Progressive, well-differentiated, non-functional neuroendocrine tumors (NET) of GI or lung origin
- ☐ Advanced renal cell carcinoma (RCC)
- ☐ Renal angiomyolipoma and tuberous sclerosis complex (TSC)
- ☐ Subependymal giant cell astrocytoma (SEGA) associated with tuberous sclerosis complex (TSC)
- ☐ Other

Q2. If you selected "other" in question 1, please provide documentation that use is consistent with a category 1 per NCCN compendia or guidelines.

Q3. Please provide ICD code(s) for diagnosis.

Q4. Is the prescribing physician a hematologist or oncologist?

☐ Yes ☐ No

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Q5. If RCC: Has the patient demonstrated disease progression or intolerance following treatment with Sutent (sunitinib) or Nexavar (sorafenib)?

☐ Yes ☐ No

Q6. If SEGA: Is the patient a candidate for surgical resection?

☐ Yes ☐ No

Q7. If PNET or NET: Is the tumor unresectable, locally advanced, or metastatic?

☐ Yes ☐ No

Q8. If breast cancer: Is the patient a postmenopausal woman?

☐ Yes ☐ No

Q9. If breast cancer: Is Afinitor being used in combination with exemestane?

☐ Yes ☐ No

Q10. If breast cancer: Has the patient failed treatment with letrozole or anastrozole?

☐ Yes ☐ No

Q11. If renal angiomyolipoma and tuberous sclerosis complex (TSC): Does the patient require immediate surgery?

☐ Yes ☐ No

Q12. Who is the ENTITY that will be submitting the CLAIM for the DRUG and seeking reimbursement?

☐ Pharmacy
☐ Individual prescriber
☐ Provider or specialty group
☐ Facility
☐ Other (please specify)

Q13. Provide name and NPI of the billing entity

Q14. Will the claim for the drug be submitted as a MEDICAL claim or PHARMACY claim (Note: If a pharmacy will be submitting a MEDICAL claim for drug reimbursement, answer MEDICAL)?

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Patient Name:	**Prescriber Name:** **Supervising Physician:**

☐ Medical	☐ Pharmacy
Q15. 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

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.