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:_____ Prescriber Name:_____

Prescriber Phone:_____ Prescriber Fax:_____ Specialty:_____

Criteria

Page 1 of 2—Please complete and return <u>all</u> 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, fulvestrant, or tamoxifen? 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☐

*For indications including **Tuberous Sclerosis Complex (TSC)**, please select one of the following and provide clinical documentation to support the specific diagnosis:*

- ❑ **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☐

Please complete and return <u>all</u> pages. Failure to complete all pages will result in processing delays.

<u>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</u>	<u>CONFIDENTIALITY NOTICE</u>
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.*

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

1. Please indicate the diagnosis and information, continued:
   - ❑ **Tuberous Sclerosis Complex (TSC)-associated partial-onset seizures (continued)**
     - 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 ☐
     - 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:** _____

Additional Information: _____

_____

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 [tuberous sclerosis complex (TSC)-associated partial-onset seizures diagnosis]:

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

Additional Information: _____

_____

Please complete and return <u>all</u> 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.

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