Afinitor (Everolimus)

Prior Authorization Form Curascript Fax (888) 773-7386

Last Name	First Name	Prescriber's Name	Specialty
Home Phone	Work Phone	Office Phone	Office Fax
Home Address City State ZIP		Address City State ZIP	
SCAN ID number	Date of Birth	Est. Start Date	Office Contact
For Specialty Medications Only: Shipping Address (if different from home address) ☐ Physician ☐ Home		Special Instructions (i.e. Non-English Speaking Patient, etc.)	

Medication:		Diagnosis:	
Sig:	Qty:	Refills:	ICD 9 Code:

Secondary/ Supplemental Insurance Company	Phone	Name of Insured	ID Number	Group Number

1. **Is the diagnosis or indication for the treatment of patients with advanced renal cell carcinoma?**
2. **Has the patient failed Sutent, Nexavar or both prior to the initiation of Afinitor?**
   Please list medications tried and failed and the duration of treatment.
3. **Will Afinitor be co-administered with strong or moderate inhibitors of CYP3A4 and PgP, such as ketoconazole, itraconazole, erythromycin, verapamil, diltiazem, etc?**
4. **Is Afinitor being prescribed by an Oncologist?**
5. **What are the patients CBC, SrCr, BUN, serum glucose, and lipid panel prior to the initiation of Afinitor?**
6. **Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel is important to this review?**

Physician's Signature: ____NPI/DEA #: ______________________ Date:

For Internal Use Only
☐ Approved ☐ Denied Reviewer's Initials ___________________ Decision Date ____________________
Comments____

Notice: **Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.** Our response time for prescription drug coverage requests is 72 hours. View our formulary and Prior Authorization forms online at http://www.scanhealthplan.com.