



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
SCAN ID number	Date of Birth	Est. Start Date	Office Contact
For Specialty Medications Only: Shipping Address (if different from home address) <input type="checkbox"/> Physician <input type="checkbox"/> 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
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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: _____
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<u>For Internal Use Only</u>
<input type="checkbox"/> Approved <input type="checkbox"/> Denied
Reviewer's Initials _____ Decision Date _____
Comments _____