

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 all 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 ___

Page 1 of 2

Please complete and return all pages. Failure to complete all pages will result in processing delays.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

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

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State of Oklahoma
Oklahoma Health Care Authority
Afinitor® (Everolimus) Prior Authorization Form

Member Name: _____ Date of Birth: _____ Member ID#: _____

Criteria

Page 2 of 2—Please complete and return all 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: _____

Page 2 of 2

Please complete and return all 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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