OPTUMRx®

OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Afinitor® & Afinitor® Disperz™ Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Advanced neuroendocrine tumors of pancreatic origin (pNET)
- ❑ Advanced renal cell carcinoma (RCC)
- ❑ Breast cancer
- ❑ Neuroendocrine tumors of gastrointestinal or lung origin
- ❑ Renal angiomyolipoma with tuberous sclerosis complex (TSC)
- ❑ Subependymal giant cell astrocytoma (SEGA) associated with tuberous sclerosis (TS)
- ❑ Tuberous sclerosis complex (TSC)-associated partial-onset seizures
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Provider's Specialty:

Select if the requested medication is prescribed by or in consultation with one of the following:
❑ Oncologist ❑ Nephrologist ❑ Neurologist

For advanced neuroendocrine tumors of pancreatic origin (pNET), answer the following:

Does the patient have progressive pNET? ❑ **Yes** ❑ **No**
Does the patient have unresectable, locally advanced disease? ❑ **Yes** ❑ **No**
Does the patient have metastatic disease? ❑ **Yes** ❑ **No**

For advanced renal cell carcinoma (RCC), answer the following:

Does the patient have advanced/metastatic RCC? ❑ **Yes** ❑ **No**
Does the patient have history of failure with Sutent (sunitinib) or Nexavar (sorafenib)? ❑ **Yes** ❑ **No**

For breast cancer, answer the following:

Does the patient have advanced disease? ❑ **Yes** ❑ **No**
Does the patient have hormone receptor (HR) positive breast cancer? ❑ **Yes** ❑ **No**
Does the patient have HER-2 negative breast cancer? ❑ **Yes** ❑ **No**
Does the patient have history of failure, contraindication, or intolerance to Femara (letrozole) or Arimidex (anastrozole)? ❑ **Yes** ❑ **No**
Will the requested medication be used in combination with Aromasin (exemestane)? ❑ **Yes** ❑ **No**

For neuroendocrine tumors of gastrointestinal or lung origin, answer the following:

Does the patient have progressive, well-differentiated, non-functional neuroendocrine tumors of gastrointestinal or lung origin? ❑ **Yes** ❑ **No**
Does the patient have unresectable, locally advanced disease? ❑ **Yes** ❑ **No**
Does the patient have metastatic disease? ❑ **Yes** ❑ **No**

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For renal angiomyolipoma with tuberous sclerosis complex (TSC), answer the following:
Does the patient require immediate surgery? ❑ **Yes** ❑ **No**

For subependymal giant cell astrocytoma (SEGA) associated with tuberous sclerosis, answer the following:
Is the patient a candidate for curative resection? ❑ **Yes** ❑ **No**

For tuberous sclerosis complex (TSC)-associated partial onset seizures, answer the following:
Will the requested medication be used as adjunctive therapy? ❑ **Yes** ❑ **No**

Reauthorization:

For tuberous sclerosis complex (TSC)-associated partial onset seizures, answer the following:
Has the patient had a reduction in seizure frequency while on therapy? ❑ **Yes** ❑ **No**

For all other indications, answer the following:
Does the patient show evidence of progressive disease while on therapy? ❑ **Yes** ❑ **No**

Quantity Limit Requests:
What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?
- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.