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 tumor (NET)
- ❑ Advanced renal cell carcinoma (RCC)
- ❑ Breast cancer
- ❑ Renal angiomyolipoma with tuberous sclerosis complex (TSC)
- ❑ Subependymal giant cell astrocytoma (SEGA)
- ❑ Tuberous sclerosis complex (TSC)-associated partial-onset seizures
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is this request for continuation of prior Afinitor therapy? ❑ **Yes** ❑ **No**

Has the patient been on Afinitor within the past 120 days? ❑ **Yes** ❑ **No**

Select if Afinitor is prescribed by or in consultation with one of the following specialists:

❑ Oncologist ❑ Neuro-oncologist ❑ Nephrologist ❑ Neurologist

For advanced neuroendocrine tumor (NET), also answer the following:

Select the patient's diagnosis:

- ❑ Neuroendocrine tumors of pancreatic origin (pNET)
- ❑ Neuroendocrine tumors of gastrointestinal (GI) origin
- ❑ Neuroendocrine tumors of lung origin
- ❑ Neuroendocrine tumors of thymic origin

Select if the tumors have the following characteristics:

❑ Progressive ❑ Non-functional ❑ Unresectable
❑ Well-differentiated ❑ Locally advanced ❑ Metastatic

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

Select if the patient has the following disease characteristics:

❑ Advanced ❑ Relapsed
❑ Metastatic (Stage IV disease) ❑ Medically or surgically unresectable tumor

Select the patient's cell histology:

- ❑ Non-clear cell histology
- ❑ Predominately clear cell histology

Select if the patient has had trial and failure, contraindication, or intolerance to the following tyrosine kinase inhibitor therapies:

- ❑ Nexavar (sorafenib)
- ❑ Sutent (sunitinib)
- ❑ Other: _____

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

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For breast cancer, also answer the following:

Does the patient have advanced disease? ❑ **Yes** ❑ **No**

Does the patient have hormone receptor (HR) positive disease? ❑ **Yes** ❑ **No**

Does the patient have human epidermal receptor 2 (HER-2) negative disease? ❑ **Yes** ❑ **No**

Does the patient have recurrent or metastatic disease? ❑ **Yes** ❑ **No**

Select the patient's gender:

- ❑ Postmenopausal woman
- ❑ Premenopausal woman
- ❑ Male

Is the patient being treated with ovarian ablation/suppression? ❑ **Yes** ❑ **No**

Select if the patient has had trial and failure, contraindication, or intolerance to the following:

- ❑ Arimidex (anastrozole)
- ❑ Femara (letrozole)
- ❑ Tamoxifen

Select if the requested medication be used in combination with the following:

- ❑ Aromasin (exemestane)
- ❑ Fulvestrant
- ❑ Tamoxifen

For renal angiomyolipoma with tuberous sclerosis complex (TSC), also answer the following:

Does the patient require immediate surgery? ❑ **Yes** ❑ **No**

For subependymal giant cell astrocytoma (SEGA), also answer the following:

Does the patient have SEGA associated with tuberous sclerosis (TS)? ❑ **Yes** ❑ **No**

Does the patient require therapeutic intervention? ❑ **Yes** ❑ **No**

Is the patient a candidate for curative surgical resection? ❑ **Yes** ❑ **No**

For tuberous sclerosis complex (TSC)-associated partial-onset seizures, also answer the following:

Will the requested medication be used as adjunctive 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
- ❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: _____
- ❑ 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.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
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.