Prescriber Criteria Form Afinitor 2024 PA Fax 415-A v1 010124.docx Afinitor, Afinitor Disperz (everolimus), Everolimus Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714**. with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Afinitor.

Drug Name (select from list of drugs shown):

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of renal cell carcinoma? [If no, then skip to question 3.]	Yes	No
2	Is the disease relapsed, advanced, or stage IV? [No further questions.]	Yes	No
3	Does the patient have a diagnosis of recurrent unresectable, advanced, or metastatic breast cancer? [If no, then skip to question 8.]	Yes	No
4	Is the disease hormone receptor (HR) positive? [If no, then no further questions.]	Yes	No
5	Is the disease human epidermal growth factor receptor 2 (HER2) negative? [If no, then no further questions.]	Yes	No
6	Is the requested medication prescribed in combination with exemestane, fulvestrant, or tamoxifen? [If no, then no further questions.]	Yes	No
7	Will the requested medication be used for subsequent treatment? [No further questions.]	Yes	No

8	Does the patient have tuberous sclerosis complex? [If yes, then no further questions.]	Yes	No
9	Does the patient have a diagnosis of subependymal giant cell astrocytoma (SEGA)? [If no, then skip to question 11.]	Yes	No
10	Will the requested drug be given as adjuvant treatment? [No further questions.]	Yes	No
11	Does the patient have a diagnosis of soft tissue sarcoma? [If no, then skip to question 13.]	Yes	No
12	Is the soft tissue sarcoma subtype any of the following: A) perivascular epithelioid cell tumors (PEComa), B) lymphangioleiomyomatosis, C) angiomyolipoma? [No further questions.]	Yes	No
13	Does the patient have thyroid carcinoma? [If no, then skip to question 15.]	Yes	No
14	Does the disease express any of the following histologies: A) papillary, B) Hurthle cell, C) follicular? [No further questions.]	Yes	No
15	Does the patient have a diagnosis of gastrointestinal stromal tumor? [If no, then skip to question 18.]	Yes	No
16	Is the disease recurrent/progressive, unresectable, or metastatic? [If no, then no further questions.]	Yes	No
17	Has the patient failed a Food and Drug Administration (FDA)-approved therapy (for example, imatinib, sunitinib, regorafenib, ripretinib)? [No further questions.]	Yes	No
18	Does the patient have a diagnosis of: A) symptomatic or relapsed/refractory Erdheim-Chester Disease (ECD), B) symptomatic or relapsed/refractory Rosai-Dorfman Disease, C) Langerhans Cell Histiocytosis (LCH)? [If no, then skip to question 20.]	Yes	No
19	Does the patient have a phosphatidylinositol-4,5-bisphosphate 3-kinase catalytic subunit alpha (PIK3CA) mutation? [No further questions.]	Yes	No
20	Does the patient have any of the following diagnoses: A) neuroendocrine tumor of pancreatic origin (pNET), B) neuroendocrine tumor of lung origin, C) neuroendocrine tumor of gastrointestinal origin, D) neuroendocrine tumor of the thymus, E) well differentiated grade 3 neuroendocrine tumors, F) classic Hodgkin lymphoma, G) thymomas and thymic carcinomas, H) previously treated Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, I) endometrial carcinoma?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ Date:_____