Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (MEDICAID)

Afinitor – Afinitor Disperz (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health New Jersey at **1-855-296-0323**.
When conditions are met, we will authorize the coverage of Afinitor – Afinitor Disperz (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

Afinitor (everolimus tablets) Afinitor Disperz (everolimus tablets for oral suspension)

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Member information

Member name: _____
Member ID: _____
Member Group No.: _____
Member DOB: _____
Member phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis: _____ **ICD Code:** _____

Circle the appropriate answer for each question.

1. Has this plan authorized this medication in the past for this member (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 3.]

2. Does the member show clinically significant improvement or stabilization of the disease state? Y N

   [No further questions.]

3. Is the request for Afinitor Disperz? Y N

   [If no, skip to question 7.]

4. Is the member a pediatric member 1 year of age and older? Y N

   [If no, then no further questions.]

5. Does the member have a diagnosis of tuberous sclerosis complex (TSC) with subependymal giant cell astrocytoma (SEGA)? Y N

   [If no, then no further questions.]

6. Is the member a candidate for surgical resection? Y N

   [If yes, then no further questions.] [If no, skip to question 35.]

7. Is the member 18 years of age or older? Y N

   [If no, then no further questions.]

8. Does the member have a diagnosis of advanced renal cell carcinoma (RCC)? Y N

   [If no, skip to question 11.]

9. Is the renal cell carcinoma of NON-clear cell histology? Y N

   [If yes, skip to question 35.]

10. Has the member failed treatment with sunitinib (Sutent) or sorafenib (Nexavar)? Y N

    [If yes, skip to question 35.] [If no, then no further questions.]

11. Does the member have a diagnosis of tuberous sclerosis complex (TSC)? Y N

    [If no, skip to question 13.]

12. Is the request for a member with renal angiomyolipoma that does not require immediate surgery? Y N

    [If yes, skip to question 35.] [If no, then no further questions.]

13. Is the request for a member with subependymal giant cell tumor (SEGA) who is not a candidate for surgical resection? Y N

    [If yes, skip to question 35.]

14. Does the member have a diagnosis of advanced neuroendocrine tumor(s) (NET)? Y N

    [If no, then skip to question 17.]

    [Note: Afinitor is not indicated for the treatment of members with functional carcinoid tumors.]

15. Is the request for a member with a progressive neuroendocrine tumor that is of pancreatic origin (PNET)? Y N

    [If yes, skip to question 35.]

16. Is the request for a member with a progressive, well-differentiated, non-functional neuroendocrine tumor (NET) of the gastrointestinal tract or lung? Y N

    [If yes, skip to question 35.] [If no, then no further questions.]

17. Does the member have a diagnosis of hormone receptor-positive (HR+) (i.e., estrogen-receptor [ER+] positive or progesterone-receptor positive [PR+]) AND HER2 (human epidermal growth factor receptor 2)-negative breast cancer? Y N

    [If no, skip to question 21.]

18. Will Afinitor be used in combination with exemestane (Aromasin)? Y N

    [If no, then no further questions.]

19. Has the member failed treatment with letrozole (Femara), anastrozole (Arimidex) or tamoxifen? Y N

    [If no, then no further questions.]

20. Is the member postmenopausal? Y N

    [If yes, skip to question 35.] [If no, then no further questions.]

21. Does the member have a diagnosis of Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma? Y N

    [If no, skip to question 23.]

22. Has the member had failure with a first line chemotherapy regimen (bendamustine/rituximab, bortezomib/dexamethasone/rituximab, rituximab/cyclophosphamide/dexamethasone and others)? Y N

    [If yes, skip to question 35.] [If no, then no further questions.]

23. Does the member have a diagnosis of soft tissue sarcoma? Y N

    [If no, skip to question 27.]

24. Is Afinitor being requested for the treatment of perivascular epithelioid cell (PEComa)? Y N

    [If yes, skip to question 35.]

25. Is Afinitor being requested for the treatment of recurrent angiomyolipoma? Y N

    [If yes, skip to question 35.]

26. Is Afinitor being requested for the treatment of lymphangioleiomymatosis? Y N

    [If yes, skip to question 35.] [If no, then no further questions.]

27. Does the member have a diagnosis of classical Hodgkin lymphoma (CHL)? Y N

    [If no, skip to question 29.]

28. Does the member have relapsed or refractory disease (failure to first line chemotherapy regimen)? Y N

    [If yes, skip to question 35.] [If no, then no further questions.]

29. Does the member have a diagnosis of thymomas or thymic carcinomas? Y N

    [If no, skip to question 31.]

30. Has the member had failure with at least one first line chemotherapy regimen? Y N

    [If yes, skip to question 35.] [If no, then no further questions.]

31. Does the member have a diagnosis of bone cancer? Y N

    [If no, then no further questions.]

32. Does the member have relapsed, refractory or metastatic osteosarcoma? Y N

    [If no, then no further questions.]

33. Has the member failure with at least one first line chemotherapy regimen? Y N

    [If no, then no further questions.]

34. Will Afinitor be used in combination with sorafenib (Nexavar)? Y N

    [If no, then no further questions.]

35. Is requested medication prescribed by, or in consultation with, an oncologist? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature **Date**