PriorityHealth

Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**
This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Everolimus / Afinitor® / Afinitor Disperz®

Member

Last Name: _____ First Name: _____
ID #: _____ DOB: _____ Gender: _____
Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____
Provider Address: _____
Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New Request ☐ Continuation Request

Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Dosing frequency: _____

Drug product:

- ☐ everolimus oral tablet (2.5 mg, 5 mg, 7.5 mg)
- ☐ Afinitor oral tablet
- ☐ Afinitor Disperz tablet for oral suspension

Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

For this drug to be covered, the patient must meet the following criteria:

1. Must be used for a medically accepted indication*
2. For advanced renal cell carcinoma, must first try and fail sunitinib (Sutent) or sorafenib (Nexavar)
3. For advanced hormone receptor-positive, HER2-negative breast cancer in postmenopausal women:
    a. Must have tried anastrozole (Arimidex) or letrozole (Femara)
    b. Must not have had prior treatment with exemestane (Aromasin)
    c. Must be used in combination with exemestane (Aromasin)
    d. Must have an Eastern Cooperative Oncology Group (ECOG) performance status of 2 or less

All fields must be complete and legible for review. Your office will receive a response via fax.

Created 03/2020
Updated 03/2020
Last reviewed 03/2020

Medically accepted indication*

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication for a drug or biologic used in an anti-cancer chemotherapeutic regimen is a use that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- supported by one of the following references (known as compendia): National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, Micromedex DrugDex, American Hospital Formulary Service-Drug Information, Clinical Pharmacology, or Lexi-Drugs
- –– *or* –– supported in peer-reviewed medical literature appearing in regular editions of approved publications

Additional information

Note: When coverage criteria are met, coverage duration is 1 year

Priority Health Precertification Documentation

A. What is the patient's diagnosis?

- ☐ Advanced renal cell carcinoma
- ☐ Advanced hormone receptor-positive, HER2-negative breast cancer in postmenopausal women
- ☐ Progressive neuroendocrine tumors of pancreatic origin (PNET), unresectable, locally advanced or metastatic
- ☐ Progressive, well-differentiated, non-functional NET of gastrointestinal (GI) or lung origin, unresectable, locally advanced or metastatic
- ☐ Renal angiomyolipoma and tuberous sclerosis complex not requiring immediate surgery
- ☐ Tuberous sclerosis complex-associated subependymal giant cell astrocytoma (SEGA) that cannot be curatively resected
- ☐ Tuberous sclerosis complex-associated partial-onset seizures as adjunctive treatment

☐ *Other – the patient's condition is:* _____
Rationale for Other use: _____

B. For advanced renal cell carcinoma, has the patient tried and failed one of the following?

☐ Yes.

	Dates	**Outcome**
☐ sorafenib (Nexavar)	_____	_____
☐ sunitinib (Sutent)	_____	_____

☐ No. **Are you requesting an exception to the criteria?**

- ☐ Yes. ***Rationale for exception***: _____
- ☐ No

C. For advanced hormone receptor-positive, HER2-negative breast cancer has the patient met the following?

☐ Yes. ***Check all that apply. Provide supporting rationale for any item that has not been met:***

- ☐ Patient is postmenopausal
- ☐ Patient has tried anastrozole (Arimidex) or letrozole (Femara)
- ☐ Patient has NOT previously tried exemestane (Aromasin)
- ☐ Patient will take Afinitor in combination with exemestane (Aromasin)
- ☐ Patient's ECOG performance status is: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

☐ No. **Are you requesting an exception to the criteria?**

- ☐ Yes. ***Rationale for exception***: _____
- ☐ No

All fields must be complete and legible for review. Your office will receive a response via fax.

Created 03/2020
Updated 03/2020
Last reviewed 03/2020

Priority Health Medicare Exception Request *(exceptions to the above criteria)*

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would everolimus, Afinitor or Afinitor Disperz likely be the most effective option for this patient?
☐ Yes ☐ No
If yes, please explain why: _____

_____

_____

If the patient is currently using everolimus, Afinitor or Afinitor Disperz, would changing the patient's current regimen likely result in adverse effects for the patient?
☐ Yes ☐ No
If yes, please explain: _____

_____

_____

All fields must be complete and legible for review. Your office will receive a response via fax.

Created 03/2020
Updated 03/2020
Last reviewed 03/2020