



PREAUTHORIZATION FORM

Afinitor™
 (everolimus)

Therapeutic use: Treatment of patients with advanced renal cell carcinoma (RCC) after failure of treatment with sunitinib or sorafenib; treatment in patients with progressive neuroendocrine tumors (pNET) of pancreatic origin; or in patients suffering from subependymal giant cell astrocytoma (SEGA)

Quantity Limit: RCC or PNET: 5mg or 10mg tablet 1/day

SEGA: 2.5mg and 5mg tablet, up to 1 of each tablet per day

Authorization Period: 12 months

Patient's name _____

Patient's ID# DOB / /

ICD-9

Physician's name _____

Physician's Ph# () - Fax# -

Physician's signature _____ Date signed / /

Supervising Physician's name _____ (Required if requesting provider is a nurse practitioner or physician assistant)

Please check "Yes" or "No" and respond to the following requests:			
1.	Is the patient diagnosed with renal cell carcinoma?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
1a.	Has the patient previously failed one of the following medications: <input type="checkbox"/> Sunitinib (Sutent) <input type="checkbox"/> Sorafenib (Nexavar)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	Has the patient been diagnosed with progressive neuroendocrine tumors of pancreatic origin (PNET) which are unresectable, locally advanced or metastatic?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Has the patient been diagnosed with subependymal giant cell astrocytoma (SEGA) associated with tuberous sclerosis (TS)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3a.	Does the patient require therapeutic intervention?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3b.	Is the patient a candidate for curative surgical resection?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.