UnitedHealthcare Community Plan

Afinitor
PRIOR AUTHORIZATION REQUEST FORM

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form contains multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication □ New or □ Continuation of Therapy? If continuation, list start date: _____
Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Physician Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs
Please refer to www.uhccommunityplan.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

- What is the patient diagnosis? □ Yes □ No
□ Neuroendocrine Tumors □ Renal Cell Cancer □ Renal Angiomyolipoma and Tuberous Sclerosis Complex
□ Subependymal Giant Cell Astrocytoma □ Waldenstrom's Macroglobulinemia or Lymphoplasmacytic Lymphoma
□ Breast Cancer □ Classical Hodgkin Lymphoma □ Soft Tissue Sarcoma □ Bone Cancer □ Thyroid Carcinoma
□ Thymomas or Thymic Carcinomas □ Other. List Diagnosis: _____.

Requests for Neuroendocrine Tumors:
- Does the patient have one of the following diagnoses:
□ Neuroendocrine tumors of pancreatic origin □ Neuroendocrine tumors of gastrointestinal origin
□ Neuroendocrine tumors of lung origin
- Is the patient's disease progressive? □ Yes □ No
- Is the patient's disease unresectable, locally advanced, or metastatic? □ Yes □ No

Requests for Advanced Renal Cell Carcinoma:
- Has the patient's disease relapsed? □ Yes □ No
- Does the patient have a medically or surgically unresectable tumor? □ Yes □ No
- Does the patient have a diagnosis of Stage IV disease? □ Yes □ No
- Does the patient have non-clear cell histology? □ Yes □ No
- Does the patient have predominantly clear cell histology? □ Yes □ No
- Does the patient have a history of failure, contraindication, or intolerance to at least one prior tyrosine kinase inhibitor therapy [e.g., Nexavar (sorafenib), Sutent (sunitinib)]? □ Yes □ No
(If yes, complete Section D above with medication information, including dose, duration, and date of trial)

Requests for Renal Angiomyolipoma and Tuberous Sclerosis Complex:
- Does the patient require immediate surgery? □ Yes □ No

Requests for Subependymal Giant Cell Astrocytoma:
- Is the patient's diagnosis of subependymal giant cell astrocytoma associated with tuberous sclerosis? □Yes □ No
- Is the patient a candidate for curative surgical resection? □Yes □ No

Requests for Waldenstroms Macroglobulinemia or Lymphoplasmacytic Lymphoma:
- Is the patient's disease non-responsive to primary treatment? □ Yes □ No
- Is the patient's disease progressive? □ Yes □ No
- Has the patient's disease relapsed? □ Yes □ No

Requests for Breast Cancer:
- Is the patient's disease recurrent? □ Yes □ No
- Is the patient's disease metastatic? □ Yes □ No
- Is the patient's disease hormone receptor positive [i.e., estrogen-receptor-positive or progesterone-receptor-positive]? □ Yes □ No
- Is the patient's disease human epidermal growth factor receptor 2 (HER2)-negative? □ Yes □ No
- Is the patient a postmenopausal woman? □ Yes □ No
- Has the patient's disease progressed while on or within 12 months of non-steroidal aromatase inhibitor [e.g., Arimidex (anastrozole), Femara (letrozole)] therapy? □ Yes □ No
(If yes, complete Section D above with medication information, including dose, duration, and progression date)
- Has the patient been treated with tamoxifen at any time? □ Yes □ No
(If yes, complete Section D above with medication information, including dose, duration, and date of trial)
- Is Afinitor being used in combination with Aromasin (exemestane)? □ Yes □ No

Requests for Hodgkin Lymphoma:
- Is the patient's disease refractory? □ Yes □ No
- Has the patient's disease relapsed? □ Yes □ No

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Requests for Soft Tissue Sarcoma:

- **Which one of the following diagnoses does the patient have:**
  □ PEComa (perivascular epitheliod cell tumor) □ Recurrent Angiomyolipoma □ Lymphangioleiomyomatosis

Requests for Bone Cancer:

- **Does the patient have one of the following diagnoses:**
  □ Osteosarcoma □ Dedifferentiated chondrosarcoma □ High-grade undifferentiated pleomorphic sarcoma
- **Does the patient have a history of failure, contraindication, or intolerance to a first-line chemotherapy regimen?**
  □ **Yes** □ **No**
  (If yes, complete Section D above with medication information, including dose, duration, and date of trial)
- **Is Afinitor being used in combination with Nexavar (sorafenib)?** □ **Yes** □ **No**

Requests for Thymomas and Thymic Carcinomas:

- **Does the patient have a history of failure, contraindication, or intolerance to a first-line chemotherapy regimen?**
  □ **Yes** □ **No**
  (If yes, complete Section D above with medication information, including dose, duration, and date of trial)

Requests for Thyroid Carcinoma:

- **Does the patient have one of the following diagnoses:**
  □ Follicular carcinoma □ Hürthle cell carcinoma □ Papillary carcinoma
- **Does the patient have one of the following diseases:**
  □ Unresectable recurrent disease □ Persistent locoregional disease □ Metastatic disease
- **Does the patient have symptomatic or progressive disease?** □ **Yes** □ **No**
- **Is the patient's disease refractory to radioactive iodine treatment?** □ **Yes** □ **No**

Requests for Continuation of Therapy:

- **Does the patient show evidence of progressive disease while on Afinitor therapy?** □ **Yes** □ **No**

Physician Signature: _____ **Date:** _____