AFINITOR

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES **PHONE 800-979-UPMC (8762)** **FAX 412-454-7722**

PLEASE TYPE OR PRINT NEATLY. ***Incomplete responses may delay this request.***

Office Contact:	**Provider Specialty:**
Provider First Name:	**Provider Last Name:**
Provider Phone:	**Provider Fax:**

Patient Name:	**Patient UPMC Health Plan ID Number:**	**Patient Age:**	**Patient DOB:**

Drug Requested: ❑ **Brand** ❑ **Generic**	**Strength:**	**Frequency:**	**Expected length of therapy:**

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

❑ **New medication** ❑ **Ongoing medication**	**If ongoing, provide date started:**	**If medication is ongoing, Did member Show improvement while on therapy?**	❑**Yes** ❑**No**

Place of administration? ❑**Physician Office** ❑**Hospital/Facility**	**Please indicate how medication will be billed:** ❑ **Billed directly by the provider via JCODE** **Provide JCODE:_____** ❑ **Billed by a pharmacy and delivered to the provider** ❑ **Billed by a pharmacy and delivered to the patient**
Please provide facility/provider name and address:	

Please provide pertinent progress notes and lab/radiology reports that describe the member's current disease status.

☐ **Chart documentation enclosed** ☐ **Chart documentation not available**

Please indicate the diagnosis and answer the corresponding questions:

❑Renal Cell Carcinoma	Please indicate status:	❑ Advanced	❑ Metastatic
	Please indicate stage:		
	Has the member tried and failed treatment with sunitinib (Sutent)? ❑Yes ❑No		
	Has the member tried and failed treatment with sorafenib (Nexavar)? ❑Yes ❑No		
	If yes, please complete below:		

Medication Name	**Strength/Frequency**	**Dates of Therapy**	**Reason for Discontinuation**

❑ Other Diagnosis, please list:	Please provide clinical literature/studies to support request for off-label use. ☐ Clinical literature/studies enclosed ☐ Clinical literature/studies not available

Is Afinitor being used in combination with any other therapies? ❑Yes ❑No If yes, please list below.

Medication Name	**Strength/Frequency**	**Dates of Therapy**

Please list below any other previous therapies tried:

Medication Name	**Strength/Frequency**	**Dates of Therapy**	**Reason for Discontinuation**

Please provide any additional information which should be considered in the space below: