{{PANUMCODE}}

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to {{COMPANY_NAME}} at {{CLIENT_PAG_FAX}}. Please contact {{COMPANY_NAME}} at {{CLIENT_PAG_PHONE}} with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of {{DRUGNAME}}.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}} **Patient Phone:** <<MEMPHONE>>
Specialty: _____ **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Physician Office Address: <<PHYADDRESS1>> <<PHYADDRESS2>> <<PHYCITY>>, <<PHYSTATE>> <<PHYZIP>>
Drug Name: {{DRUGNAME}}

Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: <<DIAGNOSIS>> **ICD Code**: <<ICD9>>

1. What is the requested drug?
   - ❑ Afinitor 2.5 mg
   - ❑ Afinitor 5 mg
   - ❑ Afinitor 7.5 mg
   - ❑ Afinitor 10 mg
   - ❑ Afinitor Disperz 2 mg
   - ❑ Afinitor Disperz 3 mg
   - ❑ Afinitor Disperz 5 mg
   - ❑ everolimus 2 mg
   - ❑ everolimus 2.5 mg
   - ❑ everolimus 3 mg
   - ❑ everolimus 5 mg
   - ❑ everolimus 7.5 mg
   - ❑ everolimus 10 mg

2. What is the patient's diagnosis?
   - ❑ Breast cancer
   - ❑ Neuroendocrine tumors of the pancreas
   - ❑ Neuroendocrine tumors of the gastrointestinal tract
   - ❑ Neuroendocrine tumors, well differentiated Grade 3
   - ❑ Gastrointestinal stromal tumors (GIST)
   - ❑ Thymoma or thymic carcinoma
   - ❑ Thyroid carcinoma (papillary, oncocytic, or follicular)
   - ❑ Renal cell carcinoma
   - ❑ Neuroendocrine tumors of the thymus
   - ❑ Neuroendocrine tumors of the lung
   - ❑ Tuberous sclerosis complex (TSC)
   - ❑ Soft Tissue Sarcoma
   - ❑ Classic Hodgkin lymphoma
   - ❑ Uterine neoplasms
   - ❑ Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma
   - ❑ Central nervous system cancers [Glioma (including glioblastoma), meningioma, or subependymal giant cell astrocytoma (SEGA)]
   - ❑ Histiocytic Neoplasms [Erdheim-Chester Disease (ECD), Rosai-Dorfman Disease, or Langerhans Cell Histiocytosis (LCH)]
   - ❑ Other _____

3. What is the ICD-10 code? _____

4. Is this a request for continuation of therapy with the requested drug?
   ❑ Yes ❑ No *If No, skip to diagnosis section.*

5. Is there evidence of disease progression or an unacceptable toxicity while on the current regimen?
   ❑ Yes ❑ No *No further questions.*

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Breast Cancer

1. What is the clinical setting in which the requested drug will be used?
   - ❑ Recurrent unresectable disease
   - ❑ Advanced disease
   - ❑ Metastatic disease
   - ❑ Other: _____

2. What is the tumor's hormone receptor (HR) status? ***ACTION REQUIRED: Please attach chart note(s) or test results of hormone receptor (HR) status.*** ❑ HR Positive ❑ HR Negative ❑ Unknown
3. What is the tumor's human epidermal growth factor receptor-2 (HER2) status? ***ACTION REQUIRED: Please attach chart note(s) or test results of human epidermal growth factor receptor-2 (HER2) status.*** ❑ HER2 Positive ❑ HER2 Negative ❑ Unknown
4. Is the requested drug being used in combination with exemestane (Aromasin), fulvestrant (Faslodex), or tamoxifen? ❑ Yes ❑ No
5. What is the place in therapy in which the requested drug will be used? ❑ First-line treatment ❑ Subsequent treatment

Section B: Renal Cell Carcinoma

1. What is the clinical setting in which the requested will be used? ❑ Advanced disease ❑ Relapsed disease ❑ Stage IV disease ❑ Other: _____
2. What is the tumor's histology? ❑ Clear cell ❑ Non-clear cell ❑ Other or unknown _____
3. Please indicate how the drug will be given: ❑ Single agent ❑ In combination with lenvatinib (Lenvima) ❑ In combination with bevacizumab (Avastin) ❑ Other: _____
4. What is the place in therapy in which the requested drug will be used? ❑ First-line treatment ❑ Subsequent treatment

Section C: Soft Tissue Sarcoma

1. What is the soft tissue sarcoma subtype? ❑ Perivascular epithelioid cell (PEComa) ❑ Angiomyolipoma ❑ Lymphangioleiomyomatosis ❑ Other _____
2. What is the clinical setting in which the requested will be used? ❑ Recurrent disease ❑ Locally advanced unresectable disease ❑ Metastatic disease ❑ Other: _____
3. Will the requested drug be given as single agent therapy? ❑ Yes ❑ No

Section D: Gastrointestinal Stromal Tumor (GIST)

1. What is the clinical setting in which the requested will be used? ❑ Residual disease ❑ Metastatic/tumor rupture disease ❑ Recurrent disease ❑ Unresectable disease ❑ Other: _____
2. Has the patient failed at least four FDA-approved therapies (e.g., imatinib [Gleevec], sunitinib [Sutent], regorafenib [Stivarga], ripretinib [Qinlock])? ❑ Yes ❑ No
3. Will the requested drug be given in combination with either imatinib (Gleevec), sunitinib (Sutent), or regorafenib (Stivarga)? ❑ Yes ❑ No

Section E: Thymoma or Thymic Carcinoma

1. Will the requested drug be given as a single agent? ❑ Yes ❑ No

Section F: Classic Hodgkin Lymphoma

1. What is the clinical setting in which the requested drug will be used? ❑ Relapsed disease ❑ Refractory disease ❑ Other: _____
2. Has the patient failed at least 3 prior therapies? ❑ Yes ❑ No

3. Will the requested drug be given as single agent therapy? ❑ Yes ❑ No

Section G: Waldenstrom's Macroglobulinemia/Lymphoplasmacytic Lymphoma
1. Has the disease been treated previously? ❑ Yes ❑ No
2. Will the requested drug be given as single agent therapy? ❑ Yes ❑ No

Section H: Thyroid carcinoma (papillary, oncocytic, or follicular)
1. What is the tumor's histology?
   ❑ Papillary ❑ Oncocytic ❑ Follicular ❑ Other _____
2. Is the patient's thyroid carcinoma amenable to radioactive iodine (RAI) therapy? ❑ Yes ❑ No
3. Is the disease progressive and/or symptomatic? ❑ Yes ❑ No

Section I: Uterine Neoplasms
1. Which type of uterine neoplasm is being treated?
   ❑ Endometrial carcinoma ❑ Uterine sarcoma, *skip to #3*
   ❑ Other _____
2. Will the requested drug be given in combination with letrozole (Femara)?
   ❑ Yes ❑ No *No further questions*.
3. What is the place in therapy in which the requested drug will be used?
   ❑ First-line treatment ❑ Subsequent treatment
4. Will the requested drug be given as a single agent? ❑ Yes ❑ No

Section J: Central nervous system cancers [Glioma (including glioblastoma), meningioma, or subependymal giant cell astrocytoma (SEGA)]
1. Which type of central nervous system cancer is being treated?
   ❑ Glioma (including glioblastoma) or meningioma, *no further questions.*
   ❑ Subependymal giant cell astrocytoma (SEGA)
   ❑ Other _____
2. Will the requested drug be used as adjuvant treatment? ❑ Yes ❑ No *If No, no further questions.*
3. Will the requested drug be used as a single agent? ❑ Yes ❑ No

Section K: Histiocytic Neoplasms [Erdheim-Chester Disease (ECD), Rosai-Dorfman Disease, or Langerhans Cell Histiocytosis (LCH)]
1. Does the patient's disease have a phosphatidylinositol-4,5-bisphosphate 3-kinase catalytic subunit alpha (PIK3CA) mutation? ***ACTION REQUIRED: If Yes, please attach chart note(s) or test results of PIK3CA mutation status.*** ❑ Yes ❑ No ❑ Unknown
2. What is the histiocytic neoplasm subtype?
   ❑ Erdheim-Chester Disease (ECD) ❑ Rosai-Dorfman Disease
   ❑ Langerhans Cell Histiocytosis (LCH), s*kip to #4* ❑ Other _____
3. What is the histiocytic neoplasm subtype?
   ❑ Symptomatic disease ❑ Relapsed/refractory disease ❑ Other, please specify.
   _____
4. Will the requested medication be used as a single agent? ❑ Yes ❑ No

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____
Prescriber (Or Authorized) Signature and Date