



Prior Authorization Form

**Arkansas Blue Cross and Blue Shield (Medicare)
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)
Afinitor (Medicare Prior Authorization)**

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS|Caremark at 1-888-836-0730.
Please contact CVS|Caremark at 1-800-294-5979 with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Afinitor (Medicare Prior Authorization).

Drug Name (select from list of drugs shown)
Afinitor (everolimus)

Patient Information

Patient
Name: _____
Patient ID: _____
Patient
Group No.: _____
Patient
DOB: _____

Prescribing Physician

Physician
Name: _____
Physician
Phone: _____
Physician
Fax: _____
Physician
Address: _____
City, State,
Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each applicable question.

- | | | |
|---------------------------------------------------------------------------------------------------------------|---|---|
| 1. Does the patient have a diagnosis of advanced renal cell carcinoma (RCC)? | Y | N |
| [If the answer to this question is no, then no further questions.] | | |
| 2. Has the patient tried and failed previous treatment with either Sutent (sunitinib) or Nexavar (sorafenib)? | Y | N |

Comments: _____

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date