



CONTAINS CONFIDENTIAL PATIENT INFORMATION

Afinitor (everolimus)

Complete form in its entirety and fax to:
Prior Authorization of Benefits (PAB) Center at (888) 831- 2243

1. PATIENT INFORMATION

2. PHYSICIAN INFORMATION

Form with fields for Patient Name, ID, DOB, Date of Rx, Phone, Email, Prescribing Physician, Specialty, Phone, Fax, Address, DEA, NPI, and Email Address.

3. MEDICATION

4. STRENGTH

5. DIRECTIONS

6. QUANTITY PER 30 DAYS

Form with checkboxes for Afinitor (everolimus), 5mg, 10mg, and a field for quantity per 30 days.

7. DIAGNOSIS: _____

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

Form with checkboxes for approval criteria: Patient has a diagnosis of Renal Cell Carcinoma (kidney cancer), Patient has failed treatment with Sutent (sunitinib), Patient has failed treatment with Nexavar (sorafenib).

9. PHYSICIAN SIGNATURE

Form for physician signature and date, including an important warning about confidentiality and a disclaimer.

WellPoint NextRx is a registered service mark of WellPoint, Inc. Services are provided by a WellPoint PBM (either NextRx Services, Inc. or NextRx, LLC, as applicable). WellPoint NextRx is a division of WellPoint, Inc.