

**Physician's Prior Authorization Questionnaire  
Afinitor®**

**Patient:**

**ID#:**

**DOB:**

**Patient Address:**

Afinitor® is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. What is the patient's diagnosis? *(Please do not use codes.)* \_\_\_\_\_

2. If the diagnosis is renal cell carcinoma, please answer the following:

- a. Does the patient have metastatic disease?  Yes  No
- b. Has the patient's disease progressed despite treatment with sunitinib (Sutent®) and/or sorafenib (Nexavar®)?  Yes  No
- c. Does the patient have Child-Pugh class C hepatic impairment?  Yes  No

3. If the diagnosis is metastatic gastric adenocarcinoma, advanced neuroendocrine tumor, or relapsed/refractory Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, please answer the following:

- a. Has the patient failed a previous therapy for this diagnosis?  Yes  No  
If yes, please list the therapy/therapies: \_\_\_\_\_

**Please submit medical records documenting the patient's diagnosis and disease progression.**

***This medication will be dispensed from our specialty pharmacy vendor, and there is a one tablet per day limit applied to this medication.***

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please **Print** Physician's Name & Specialty

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

**Forms are also available online at [www.usableadmin.com/providers/PharmacyForms.aspx](http://www.usableadmin.com/providers/PharmacyForms.aspx)**