CVS CAREMARK

**Fax Referral To: 800-323-2445**

**Phone: 866-278-6634**

# Afinitor® (everolimus)
## Enrollment Form
## For Blue Cross Blue Shield of Rhode Island Members

**Date:** _____ **Needs by Date (Please Specify):** _____

**Ship to:** ☐ **Patient** ☐ **Office** ☐ **Other:** _____

**PATIENT INFORMATION**

*(Complete the following **or send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
SS #: _____
Insurance ID: _____
Date of Birth: _____ Gender: _____

**PRESCRIBER INFORMATION**

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____
Contact Phone: _____

**INSURANCE INFORMATION** *(If available, please copy and attach the front and back of insurance and prescription drug card)*

**Primary Insurance:** Subscriber: _____ Subscriber ID#: _____ Name of Insurer: **Blue Cross Blue Shield of RI**

**Secondary Insurance:** Subscriber: _____ Subscriber ID#: _____ Name of Insurer: _____

**STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members**

**Diagnosis (ICD-9 Code):** ☐ _____ • Date of Diagnosis: _____

**Approval Criteria: CHECK ALL BOXES THAT APPLY**

**Please note: Any areas that are not filled out will be considered not applicable to your patient AND MAY AFFECT THE OUTCOME OF THIS REQUEST**

- Patient has a diagnosis of Renal Cell Carcinoma (kidney cancer) ☐ Yes ☐ No
- Patient has failed treatment with Sutent (sunitinib) ☐ Yes ☐ No
- Patient has failed treatment with Nexavar (sorafenib) ☐ Yes ☐ No

Note: The following compendia, American Hospital Formulary Service and U.S. Pharmacopeia Dispensing Information are considered during prior authorization review if the drug is being prescribed for a condition not listed above. Additional information may be requested if documentation in the compendia is lacking.

**PRESCRIPTION INFORMATION**

| MEDICATION | STRENGTH | DIRECTIONS | QUANTITY | REFILLS |
|---|---|---|---|---|
| ☐ Afinitor® (everolimus) | ☐ 5mg<br>☐ 10mg | _____<br>_____ | **(per 30 days)** | |

_____ _____

PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)

***IMPORTANT NOTICE:*** *This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. Afinitor PAB 090209*