PRIOR AUTHORIZATION PROGRAM REIMBURSEMENT REQUEST FORM
For cancer therapy: Afinitor (everolimus)

Please fax form to: 1-866-840-1509

Please note that the patient **AND** physician must complete this form. **All fields are mandatory and must be completed. Incomplete forms may result in your application being declined.** Please retain a copy of this form for your records.

Instructions:

1. **PLEASE PRINT CLEARLY AND COMPLETE ALL SECTIONS.**
2. The patient/plan member must complete section A.
3. Your physician must complete section B. The cost, if any, of completing this form is at the expense of the patient/plan member.
4. Please return the form to your insurance company via Pharmacy Services at TELUS Health (a service provider of your insurance company) by fax to **1-866-840-1509**.
5. If you have any questions on the application of this program or the decision on reimbursement, or to inquire on the status of your Reimbursement Request Form, please contact your insurer.

A. Information to be Completed by Patient

Employee or Insured's Name	Drug Card Number __ __ - __ __ __ __ __ __ - __ __ __ __ __ __ __ __ __ __ - __ __	
Patient's Name	Patient's Date of Birth (DD/MMM/YYYY) __ __ / __ __ __ / __ __ __ __	Relationship to Employee/Insured ❑Employee ❑Spouse ❑Dependent

Please allow two business days for a response once all information is received and complete.
Notification of the results of this request will occur Monday to Friday between 9 am and 4 pm Eastern Time.

Please provide contact information and indicate **ONE** method of preferred contact for notification of the results:

❑ E-mail me at:	❑ Call me (and leave a message if I'm not there) at:	❑ Fax me at:
❑ Contact my pharmacy: Pharmacy Name		Pharmacy Phone Number

I certify that the information provided by me is true, correct and complete to the best of my knowledge. I authorize my insurance company, TELUS Health (a service provider of my insurance company), their authorized representatives, agents and service providers to use and exchange this information needed for underwriting, administration and paying claims with any person or organization who has relevant information pertaining to this claim including health professionals, institutions and investigative agencies in the event of an audit. I authorize my insurance company and/or TELUS Health (a service provider of my insurance company) to contact any licensed physician, institution, pharmacy or person who has any records or knowledge of me or my health with respect to this submitted claim.

SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN _____

Date: (DD/MMM/YYYY): __ __ / __ __ __ / __ __ __ __

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B. Information to be Completed by Prescribing Physician

Drug Name	Strength	Dose
Afinitor (everolimus)		

Afinitor (everolimus) will be eligible for reimbursement only if the patient satisfies the conditions listed below and if the patient does not qualify for coverage under any other drug plan or government mandated program. If the patient is covered under another drug plan or government mandated program, the prior authorization program, as part of your drug benefits, may cover the portion not paid for by the primary plan. If "None of the above criteria" is indicated, the patient will not be eligible for reimbursement. **For Quebec plan members, please refer to the RAMQ exception drug criteria, if applicable.**

Eligibility Criteria

Please indicate if the patient satisfies the following criteria:

Afinitor:

- ❑ Physician confirms the patient meets the drug's Health Canada approved indication with respect to the treatment of advanced breast cancer (T990000077) in combination with exemestane after recurrence or progression following treatment with letrozole or anastrozole;
  - ❑ The patient:
    - ❑ Is postmenopausal; AND
    - ❑ Has metastatic or locally advanced breast cancer not amenable to curative treatment by surgery or radiotherapy; AND
    - ❑ Has radiological or clinical evidence of recurrence or progression on or after the last systemic therapy; AND
    - ❑ Has at least one lesion that can be accurately measured or bone lesions in the absence of measurable disease; AND
  - ❑ The prescribing physician is an oncologist; OR

- ❑ For the treatment of well- or moderately differentiated neuroendocrine tumours of pancreatic origin (PNET) (717919005) in patients with unresectable, locally advanced or metastatic disease that has progressed within the last 12 months.
  - ❑ The patient:
    - ❑ Is ≥ 18 years of age; AND
    - ❑ Has advanced (unresectable or metastatic) biopsy-proven pancreatic NET; AND
    - ❑ Has a World Health Organization (WHO) Performance Status ≤ 2; AND
  - ❑ The prescribing physician is an oncologist; OR

- ❑ For the treatment of patients with metastatic renal cell carcinoma (RCC) of clear cell morphology (702392008), after failure of initial treatment with either sunitinib* or sorafenib*.
  - ❑ The patient:
    - ❑ Is ≥ 18 years of age; AND
    - ❑ Has metastatic carcinoma with histological or cytological confirmation of clear cell RCC; AND
    - ❑ Has progressed on sunitinib and/or sorafenib within 6 months; AND
    - ❑ Has at least one measurable lesion at baseline as per the Response evaluation criteria in solid tumors (RECIST) criteria, either on physical exam or as determined by Computer Tomography (CT) Scan or Magnetic Resonance Imaging (MRI); AND
    - ❑ Has a Karnofsky Performance Status ≥70%; AND
    - ❑ Has a life expectancy ≥ 3 months; AND
  - ❑ The prescribing physician is an oncologist; OR

- ❑ For the treatment of adult patients with renal angiomyolipoma associated with tuberous sclerosis complex (TSC) (T990000081), who do not require immediate surgery.
  - ❑ The patient:
    - ❑ Is ≥ 18 years of age; AND

Eligibility Criteria

- ❑ Has clinically definite diagnosis of Tuberous Sclerosis Complex according to the modified Gomez criteria or sporadic lymphangioleiomyomatosis (LAM) (biopsy-proven or compatible chest CT scan); AND
- ❑ Has clinically definite diagnosis of renal angiomyolipoma; AND
- ❑ Has at least one Angiomyolipoma of ≥ 3 cm in its longest diameter using CT or MRI; AND

❑ The prescribing physician is an oncologist; OR

❑ For the treatment of unresectable, locally advanced or metastatic, well-differentiated, non-functional neuroendocrine tumours (NET) of gastrointestinal origin (T990000078) in adults with progressive disease.

❑ The patient:

- ❑ Is ≥ 18 year of age; AND
- ❑ Has pathologically confirmed, well differentiated (G1 or G2), advanced (unresectable or metastatic), neuroendocrine tumor of GI origin; AND
- ❑ No history of and no active symptoms related to carcinoid syndrome; AND
- ❑ Is treatment-naive or, if treatment-experienced, has progressed on or after the last treatment; AND
- ❑ Has radiological documented disease progression within 6 months; AND
- ❑ Has measurable disease; AND
- ❑ Has a World Health Organization (WHO) performance status ≤1; AND
- ❑ Has adequate bone marrow, liver and renal function; AND

❑ The prescribing physician is an oncologist; OR

❑ For the treatment of unresectable, locally advanced or metastatic, well-differentiated, non-functional neuroendocrine tumours (NET) of lung origin (T990000079) in adults with progressive disease.

❑ The patient:

- ❑ Is ≥ 18 year of age; AND
- ❑ Has pathologically confirmed, well differentiated (G1 or G2), advanced (unresectable or metastatic), neuroendocrine tumor of lung origin; AND
- ❑ No history of and no active symptoms related to carcinoid syndrome; AND
- ❑ Is treatment-naive or, if treatment-experienced, has progressed on or after the last treatment; AND
- ❑ Has radiological documented disease progression within 6 months; AND
- ❑ Has measurable disease; AND
- ❑ Has a World Health Organization (WHO) performance status ≤1; AND
- ❑ Has adequate bone marrow, liver and renal function; AND

❑ The prescribing physician is an oncologist; OR

Afinitor / Afinitor Disperz:**

❑ For the treatment of patients with subependymal giant cell astrocytoma (SEGA) associated with tuberous sclerosis complex (TSC) (T990000080) that have demonstrated serial growth, who are not candidates for surgical resection and for whom immediate surgical intervention is not required.

❑ The patient:

- ❑ Is ≥ 1 year of age; AND
- ❑ Has a definite diagnosis of Tuberous Sclerosis according to the modified Gomez criteria; AND
- ❑ Has at least one Subependymal Giant Cell Astrocytoma of at least 1 cm in diameter; AND
- ❑ Has evidence of SEGA worsening as compared to prior MRI scans; AND

❑ The prescribing physician is an oncologist; OR

Afinitor Disperz:**

❑ For the treatment of seizures associated with Tuberous Sclerosis Complex (TSC) (T990000032) who are not satisfactorily controlled with current therapies.

❑ The patient:

- ❑ Is ≥ 2 years of age; AND
- ❑ Has a definite diagnosis of Tuberous Sclerosis Complex (TSC) according to the modified Gomez criteria; AND
- ❑ Diagnosis of partial-onset epilepsy; AND
- ❑ Prior history of failure to control partial-onset seizures despite having been treated with two or more sequential regimens of single or combined antiepileptic drugs; AND

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Eligibility Criteria
❑ The prescribing physician is a neurologist or a physician experienced with the treatment of seizures associated with TSC;
OR
❑ None of the above applies
Relevant additional information _____
*** May also be subject to prior authorization**
**** Afinitor Dispersz is only approved for treatment of SEGA and seizures associated with TSC by Health Canada**

Physician Information				
Physician's Name	License Number	Telephone Number	Fax Number	
Address		City	Province	Postal Code
Physician's Signature			Date: (DD/MMM/YYYY) __ __ / __ __ __ / __ __ __ __	