EXPRESS SCRIPTS®

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# Prior Authorization Request

AFINITOR DISPERZ (everolimus)

## Instructions

**Please complete Part A and have your physician complete Part B.** Completion and submission is not a guarantee of approval. Any fees related to the completion of this form are the responsibility of the plan member. Drugs in the Prior Authorization Program may be eligible for reimbursement if the patient does not qualify for coverage under a primary plan or a government program. Drugs used for indications not approved by Health Canada may be denied. For Quebec plan members, RAMQ exception drug criteria may apply. The decision for approval versus denial is based on pre-defined clinical criteria, primarily based on Health Canada approved indication(s) and on supporting evidence-based clinical protocols. The plan member will be notified whether their request has been approved or denied. Please note that you have the right to appeal the decision made by Express Scripts Canada.

## Part A – Patient

**Patient information**

| | | |
|---|---|---|
| First Name: | Last Name: | |
| Insurance Carrier Name/Number: | | |
| Group Number: | Client ID: | |
| Date of Birth (YYYY/MM/DD): | Relationship: ☐ Employee ☐ Spouse ☐ Dependent | |
| Language: ☐ English ☐ French | Gender: ☐ Male ☐ Female | |
| Address: | | |
| City: | Province: | Postal Code: |
| Email address: | | |
| Telephone (home): | Telephone (cell): | Telephone (work): |

**Coordination of benefits**

| | |
|---|---|
| **Patient Assistance Program** | Is the patient enrolled in any patient assistance program? ☐ Yes ☐ No<br>Contact Name: _____ Fax: _____ |
| **Provincial Coverage** | Has the patient applied for reimbursement under a provincial plan? ☐ Yes ☐ No ☐ N/A<br>What is the coverage decision of the drug? ☐ Approved ☐ Denied ***Attach decision letter**** |
| **Primary Coverage** | Has the patient applied for reimbursement under a primary plan? ☐ Yes ☐ No ☐ N/A<br>What is the coverage decision of the drug? ☐ Approved ☐ Denied ***Attach decision letter**** |

## Authorization

On behalf of myself and my eligible dependents, I authorize my group benefit provider, and its agents, to exchange the personal information contained on this form. I give my consent on the understanding that the information will be used solely for purposes of administration and management of my group benefit plan. This consent shall continue so long as my dependents and I are covered by, or are claiming benefits under the present group contract, or any modification, renewal, or reinstatement thereof.

_____ _____

Plan Member Signature Date

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## Part B – Prescriber

Please see instructions on page 1 and complete all sections below. Incomplete forms may result in automatic denial. Please do **not** provide genetic test information or results.

## SECTION 1 – DRUG REQUESTED

| AFINITOR DISPERZ (everolimus) | ☐ New request | ☐ Renewal request* | |
|---|---|---|---|
| Dose | Administration (ex: oral, IV, etc) | Frequency | Duration |
| | | | |

Site of drug administration:

☐ Home ☐ Physician's office/Infusion clinic ☐ Hospital (outpatient) ☐ Hospital (inpatient)

* Please submit proof of prior coverage if available

## SECTION 2 – ELIGIBILITY CRITERIA

1. **Please indicate if the patient satisfies the below criteria:**

**Subependymal Giant Cell Astrocytoma**

- ☐ For the treatment of subependymal giant cell astrocytoma (SEGA) associated with tuberous sclerosis complex (TSC) that have demonstrated serial growth, AND
- ☐ The patient is 1 year of age or older, AND
- ☐ The patient is not a candidate for surgical resection and immediate surgical intervention is not required

**Tuberous Sclerosis Complex**

- ☐ For the treatment of seizures associated with tuberous sclerosis complex (TSC), AND
- ☐ The patient is 2 years of age or older, AND
- ☐ The patient has had an inadequate response to current therapies *(Please list prior therapies in the chart below)*

**OR**

- ☐ None of the above criteria applies.

Relevant additional information:

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**2. Please list previously tried therapies**

| Drug | Dosage and administration | Duration of therapy | | Reason for cessation | |
|---|---|---|---|---|---|
| | | From | To | Inadequate response | Allergy/ Intolerance |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |

## SECTION 3 – PRESCRIBER INFORMATION

| | |
|---|---|
| Physician's Name: | |
| Address: | |
| Tel: | Fax: |
| License No.: | Specialty: |
| Physician Signature: | Date: |

**Please fax or mail the completed form to Express Scripts Canada®**

**Fax:** Express Scripts Canada Clinical Services
1 (855) 712-6329

**Mail:** Express Scripts Canada Clinical Services
5770 Hurontario Street, 10th Floor
Mississauga, ON L5R 3G5