aetna®

Cyramza® (ramucirumab) Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one)*: ☐ **Oncologist** ☐ **Hematologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for ramucirumab (Cyramza): Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For All Requests: (Clinical documentation required for all requests)

☐ **Anal adenocarcinoma** ☐ **Appendiceal adenocarcinoma** ☐ **Colorectal cancer** ☐ **Small intestine adenocarcinoma**

☐ Yes ☐ No Will ramucirumab (Cyramza) be used as combination treatment with FOLFIRI (fluorouracil, leucovorin, and irinotecan) or irinotecan?
→ Please select: ☐ Combination treatment with FOLFIRI (fluorouracil, leucovorin, and irinotecan)
☐ Combination treatment with irinotecan

☐ Yes ☐ No Will ramucirumab (Cyramza) be used as primary treatment?
→ ☐ Yes ☐ No Does the patient have unresectable metachronous metastases?
☐ Yes ☐ No Has the patient had previous adjuvant therapy with FOLFOX (fluorouracil, leucovorin, and oxaliplatin) or CapeOX (capecitabine and oxaliplatin)?
→ Please select: ☐ FOLFOX ☐ CapeOX
☐ Yes ☐ No Has the adjuvant therapy been administered within the past 12 months?
→ Please indicate name and date used: Name: _____ Date: ____/____/____ - ____/____/____

☐ Yes ☐ No Will ramucirumab (Cyramza) be used as subsequent therapy?
→ ☐ Yes ☐ No Is ramucirumab (Cyramza) being used as subsequent therapy after first progression?
☐ Yes ☐ No Does the patient have unresectable advanced or metastatic disease?
→ Please select: ☐ Unresectable advanced ☐ Metastatic disease
☐ Yes ☐ No Was the disease previously treated with irinotecan-based regimens?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

☐ **Esophageal adenocarcinoma** ☐ **Esophagogastric junction (EGJ) adenocarcinoma** ☐ **Gastric adenocarcinoma**

☐ Yes ☐ No Will ramucirumab (Cyramza) be administered as palliative therapy?

Please indicate the patient's Karnofsky performance score:_____

Please indicate the patient's ECOG performance status: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

☐ Yes ☐ No Will ramucirumab (Cyramza) be used as a single agent or in combination with paclitaxel?

→ Please select: ☐ As a single agent ☐ In combination with paclitaxel

☐ Yes ☐ No Will ramucirumab (Cyramza) be used as second-line therapy or subsequent therapy?

→ Please select: ☐ As second-line therapy ☐ As subsequent therapy

☐ **Non-small cell lung cancer (NSCLC)**

☐ Yes ☐ No Will ramucirumab (Cyramza) be given as subsequent therapy?

☐ Yes ☐ No Will ramucirumab (Cyramza) be used in combination with docetaxel?

☐ Yes ☐ No Has the patient previously received treatment with docetaxel?

☐ Yes ☐ No Does the patient have metastatic disease?

Please indicate the patient's ECOG performance status: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

☐ Yes ☐ No Has the patient had disease progression while on a first-line cytotoxic regimen?

→ ☐ Yes ☐ No Has the patient had further progression while on a systemic immune checkpoint inhibitor or other systemic therapy?

→ Please provide the name of the systemic checkpoint inhibitor or systemic therapy and dates used:

Name:_____ Date: ___/___/___ - ___/___/___

→ Please provide the name of the cytotoxic regimen and dates used:

Name:_____ Date: ___/___/___ - ___/___/___

For Continuation Requests:

☐ Yes ☐ No Has the patient experienced disease progression or unacceptable toxicity while on ramucirumab (Cyramza)?

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ___/___/___

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.