Cyramza® (ramucirumab) Medication Precertification Request

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

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Phone: 1-866-503-0857
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 ☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for **Cyramza (ramucirumab):** 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):

☐ **Colorectal cancer**
☐ Yes ☐ No Will the requested medication be used in combination with either FOLFIRI (fluorouracil, leucovorin, and irinotecan) or irinotecan?
→ Please select: ☐ Combination treatment with FOLFIRI (fluorouracil, leucovorin, and irinotecan)
☐ Combination treatment with irinotecan
How is the patient's disease classified? ☐ Advanced disease ☐ Metastatic disease ☐ Other (please specify): _____

☐ **Esophageal adenocarcinoma** ☐ **Gastro-esophageal junction (GEJ) adenocarcinoma** ☐ **Gastric adenocarcinoma**
☐ Yes ☐ No Is the patient a surgical candidate?
How is the patient's disease classified? ☐ Unresectable locally advanced disease ☐ Recurrent disease ☐ Metastatic disease
☐ Other (please specify): _____
What is the clinical setting in which the requested medication will be used? ☐ As first-line treatment ☐ As subsequent treatment
☐ Yes ☐ No Will the requested medication be used as a single agent?
→ ☐ Yes ☐ No Will the requested medication be used in combination with paclitaxel?
☐ Yes ☐ No Will the requested drug be used in combination with irinotecan with or without fluorouracil?

☐ **Hepatocellular cancer**
What is the clinical setting in which the requested medication will be used? ☐ As first-line treatment ☐ As subsequent treatment
☐ Yes ☐ No Will the requested medication be used as a single agent?
☐ Yes ☐ No Does the patient have an alpha fetoprotein (AFP) of greater than or equal to 400 ng/mL?

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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.

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

How is the patient's disease classified? ☐ Advanced disease ☐ Recurrent disease ☐ Metastatic disease
☐ Other (please specify): _____

What is the clinical setting in which the requested medication will be used? ☐ As first-line treatment ☐ As subsequent treatment

☐ Yes ☐ No Does the patient have epidermal growth factor receptor (EGFR) mutation positive disease?

☐ Yes ☐ No Will the requested medication be used in combination with erlotinib?

☐ Yes ☐ No Will the requested medication be used in combination with docetaxel?

For Continuation Requests (clinical documentation required for all requests):

☐ Yes ☐ No Has the patient experienced disease progression or an unacceptable toxicity while on the requested medication?

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.