Cyramza

CareFirst Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient Name:_____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical*	❑ *Home*	❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital*	❑ *Office*	❑ *Pharmacy*

What is the ICD-10 code: _____

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

 Cyramza SGM 1679-A – 06/2024.

Criteria Questions:

1. What is the diagnosis?

❒ Gastric adenocarcinoma (If checked, go to 2)

❒ Gastro-esophageal junction (GEJ) adenocarcinoma (If checked, go to 2)

❒ Esophagogastric Junction (EGJ) adenocarcinoma (If checked, go to 2)

❒ Esophageal adenocarcinoma (If checked, go to 2)

❒ Non-small cell lung cancer (NSCLC) (If checked, go to 2)

❒ Colorectal cancer (CRC), including anal adenocarcinoma, appendiceal adenocarcinoma, colon cancer, and rectal cancer (If checked, go to 2)

❒ Hepatocellular carcinoma (HCC) (If checked, go to 2)

❒ Mesothelioma (pleural mesothelioma, pericardial mesothelioma, or tunica vaginalis testis) (If checked, go to 2)

❒ Other, please specify. _____ (If checked, go to 2)

2. Is the patient currently receiving treatment with the requested medication?

❒ Yes, *Continue to 3*

❒ No, *Continue to 7*

3. Is this request for continued treatment of non-small cell lung cancer (NSCLC)?

❒ Yes, *Continue to 4*

❒ No, *Continue to 6*

4. Does the patient have T790M negative disease?

❒ Yes, *Continue to 5*

❒ No, *Continue to 6*

5. Is there evidence of unacceptable toxicity while on the current regimen?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

6. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

7. What is the diagnosis?

❒ Gastric adenocarcinoma (If checked, go to 8)

❒ Gastro-esophageal junction (GEJ) adenocarcinoma (If checked, go to 8)

❒ Esophagogastric Junction (EGJ) adenocarcinoma (If checked, go to 8)

❒ Esophageal adenocarcinoma (If checked, go to 8)

❒ Non-small cell lung cancer (NSCLC) (If checked, go to 14)

❒ Colorectal cancer (CRC), including anal adenocarcinoma, appendiceal adenocarcinoma, colon cancer, and rectal cancer (If checked, go to 19)

❒ Hepatocellular carcinoma (If checked, go to 22)

❒ Mesothelioma (pleural mesothelioma, pericardial mesothelioma, or tunica vaginalis testis) (If checked, go to 26)

8. What is the clinical setting in which the requested drug will be used?

❒ Unresectable locally advanced disease (If checked, go to 10)

❒ Recurrent disease (If checked, go to 10)

❒ Metastatic disease (If checked, go to 10)

❒ Other, please specify. _____ (If checked, go to 9)

9. Is the patient a surgical candidate?

❒ Yes, *Continue to 10*

❒ No, *Continue to 10*

10. What is the place in therapy in which the requested drug will be used?

❒ First-line treatment (If checked, go to 11)

❒ Subsequent treatment (If checked, go to 11)

11. Will the requested drug be used as a single agent?

❒ Yes, *No Further Questions*

❒ No, *Continue to 12*

12. Will the requested drug be used in combination with paclitaxel?

❒ Yes, *No Further Questions*

❒ No, *Continue to 13*

13. Will the requested drug be used in combination with irinotecan with or without fluorouracil?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

14. What is the clinical setting in which the requested drug will be used?

❒ Advanced disease (If checked, go to 15)

❒ Recurrent disease (If checked, go to 15)

❒ Metastatic disease (If checked, go to 15)

❒ Other, please specify. _____ (If checked, go to 15)

15. Will the requested drug be used in combination with erlotinib?

❒ Yes, *Continue to 16*

❒ No, *Continue to 17*

16. Does the patient have epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 (L858R) substitution mutation positive disease? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results of EGFR mutation testing results.

❒ Yes ***ACTION REQUIRED***: Submit supporting documentation (If checked, *no further questions*)

❒ No (If checked, *no further questions*)

❒ Unknown (If checked, *no further questions*)

17. Will the requested drug be used in combination with docetaxel?

❒ Yes, *Continue to 18*
❒ No, *Continue to 18*

18. What is the place in therapy in which the requested drug will be used?

❒ First-line treatment (If checked, *no further questions*)

❒ Subsequent treatment (If checked, *no further questions*)

19. What is the clinical setting in which the requested drug will be used?

❒ Advanced disease (If checked, go to 20)

❒ Metastatic disease (If checked, go to 20)

❒ Other, please specify. _____ (If checked, go to 20)

20. Will the requested drug be used in combination with FOLFIRI (irinotecan, folinic acid, and 5-fluorouracil)?
❒ Yes, *No Further Questions*
❒ No, *Continue to 21*

21. Will the requested drug be used in combination with irinotecan?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

22. What is the place in therapy in which the requested drug will be used?

❒ First-line treatment (If checked, go to 23)

❒ Subsequent treatment (If checked, go to 23)

23. What is the clinical setting in which the requested drug will be used?

❒ Progressive disease (If checked, go to 24)

❒ Other, please specify. _____ (If checked, go to 24)

24. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 25*
❒ No, *Continue to 25*

25. Does the patient have an alpha fetoprotein (AFP) of greater than or equal to 400 ng/mL? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results of alpha fetoprotein (AFP) level results.

❒ Yes, ***ACTION REQUIRED***: Submit supporting documentation (If checked, *no further questions*)

❒ No, *No Further Questions*

❒ Unknown, *No Further Questions*

26. Which of the following applies to the patient's disease?

❒ Pleural mesothelioma (If checked, go to 27)

❒ Pericardial mesothelioma (If checked, go to 27)

❒ Tunica vaginalis testis mesothelioma (If checked, go to 27)

❒ Other, please specify. _____ (If checked, go to 27)

27. What is the place in therapy in which the requested drug will be used?

❒ First-line treatment (If checked, go to 28)

❒ Subsequent treatment (If checked, go to 28)

28. Will the requested drug be used in combination with gemcitabine?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062

Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com