BlueCross BlueShield
Federal Employee Program

CYRAMZA
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: R			Physician Signature:		
PHYSICIAN COMPLETES					

Cyramza (ramucirumab)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. Has the patient been on Cyramza continuously for the last **6 months**, excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

a. What is the patient's diagnosis?

❑Advanced or metastatic gastric cancer **OR** ❑Advanced or metastatic gastro-esophageal junction adenocarcinoma

i. Will Cyramza be used as a single agent (monotherapy)? ❑Yes ❑No*

If NO, will Cyramza be used in combination with paclitaxel? ❑Yes ❑No

ii. Has the patient received prior chemotherapy containing fluoropyrimidine or platinum? ❑Yes* ❑No

If YES, has the patient experienced disease progression on or after this therapy? ❑Yes ❑No

❑Hepatocellular Carcinoma (HCC)

i. Will Cyramza be used as a single agent (monotherapy)? ❑Yes ❑No

ii. What is the patient's alpha fetoprotein (AFP) level? _____ ng/mL

iii. Was the patient previously treated with sorafenib? ❑Yes ❑No

❑Metastatic colorectal cancer

i. Will Cyramza be used in combination with FOLFIRI? ❑Yes ❑No

ii. Has the patient received prior chemotherapy containing bevacizumab, oxaliplatin and a fluoropyrimidine? ❑Yes* ❑No

If YES, has the patient experienced disease progression while on or after this therapy? ❑Yes ❑No

❑Metastatic Non-Small Cell Lung Cancer (NSCLC)

i. Will Cyramza be used in combination with docetaxel (Taxotere)? ❑Yes ❑No

ii. Has the patient received prior chemotherapy containing platinum? ❑Yes* ❑No

If YES, has the patient experienced disease progression on or after platinum therapy? ❑Yes ❑No

iii. Does the patient have positive EGFR or ALK tumor expression? ❑Yes* ❑No

If YES, has the patient had disease progression on FDA-approved therapy? ❑Yes ❑No

iv. Will Cyramza be used as first-line treatment in combination with erlotinib (Tarceva)? ❑Yes ❑No

v. Do the tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) mutations? ❑Yes ❑No

❑Other diagnosis ***(please specify)***: _____

❑**YES** - this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

a. What is the patient's diagnosis?

❑Advanced or metastatic gastric cancer ❑Advanced or metastatic gastro-esophageal junction adenocarcinoma
❑Hepatocellular Carcinoma (HCC) ❑Metastatic Non-Small Cell Lung Cancer (NSCLC)
❑Metastatic colorectal cancer ❑Other diagnosis ***(please specify)***: _____

b. Has the patient experienced disease progression or unacceptable toxicity while on Cyramza therapy? ❑Yes ❑No

2. Does the patient have either or both of the following conditions below? ***Please select all that apply:***

❑Arterial thromboembolic events (ATEs) ❑Hemorrhage or any severe bleeding events ❑No*

If NO, if the patient develops any of the above mentioned conditions will the therapy be discontinued? ❑Yes ❑No

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***