# Cyramza

## 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's 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*

**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**

**Criteria Questions:**

1. What is the diagnosis?
   - ❑ Gastric adenocarcinoma
   - ❑ Gastro-esophageal junction (GEJ) adenocarcinoma
   - ❑ Esophageal adenocarcinoma
   - ❑ Non-small cell lung cancer (NSCLC)
   - ❑ Colorectal cancer
   - ❑ Hepatocellular carcinoma
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Is the patient currently receiving treatment with the requested medication? ❑ Yes ❑ No *If No, skip to #5*
4. Has the patient experienced disease progression or an unacceptable toxicity while receiving the requested drug/regimen? ❑ Yes ❑ No *No further questions*
5. What is the clinical setting in which the requested drug will be used?
   - ❑ As first-line treatment
   - ❑ As subsequent treatment
   - ❑ Other _____
6. Will the requested drug be used as any of the following?
   - ❑ as a single agent
   - ❑ in combination with paclitaxel
   - ❑ in combination with docetaxel
   - ❑ in combination with FOLFIRI (irinotecan, folinic acid, and 5-fluorouracil)
   - ❑ in combination with irinotecan
   - ❑ in combination with erlotinib
   - ❑ in combination with irinotecan with or without fluorouracil
   - ❑ Unknown

***Complete the following section based on the patient's diagnosis, if applicable.***

Section A: Gastric Adenocarcinoma, Gastro-Esophageal Junction (GEJ) Adenocarcinoma, Esophageal Adenocarcinoma, Non-Small Cell Lung Cancer, Colorectal Cancer

7. How is the patient's disease classified?
   - ❑ Unresectable locally advanced disease
   - ❑ Recurrent disease
   - ❑ Metastatic disease
   - ❑ Advanced disease
   - ❑ Other _____
8. *If disease is classified as other and patient's diagnosis is gastric adenocarcinoma, gastro-esophageal junction adenocarcinoma or esophageal adenocarcinoma,* is the patient a surgical candidate? ❑ Yes ❑ No
9. *If patient's diagnosis is non-small cell lung cancer,* does the patient have epidermal growth factor receptor (EGFR) mutation positive disease? ❑ Yes ❑ No

Section B: Hepatocellular Cancer

10. Does the patient have an alpha fetoprotein (AFP) of greater than or equal to 400 ng/mL? ❑ Yes ❑ No

***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)**

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