OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Cyramza® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Colon cancer
- ❑ Gastric cancer
- ❑ Non-small cell lung cancer
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Provider's Specialty:

Is Cyramza prescribed by or in consultation with an oncologist? ❑ **Yes** ❑ **No**

For colon cancer, answer the following:

Does the patient have metastatic colorectal cancer? ❑ **Yes** ❑ **No**

Will Cyramza be used in combination with irinotecan? ❑ **Yes** ❑ **No**

Will Cyramza be used in combination with FOLFIRI (irinotecan, folinic acid, and 5-fluorouracil)? ❑ **Yes** ❑ **No**

Has the patient had disease progression on or is intolerant to a prior chemotherapy regimen containing bevacizumab, oxaliplatin, and a fluoropyrimidine? ❑ **Yes** ❑ **No**

For gastric cancer, answer the following:

Select if the patient has one of the following diagnoses:

- ❑ Gastric adenocarcinoma
- ❑ Gastro-esophageal junction (GEJ) adenocarcinoma

Does the patient have locally advanced or metastatic disease? ❑ **Yes** ❑ **No**

Select if the patient's disease has progressed on or after the following first-line therapies:

- ❑ Fluoropyrimidine-containing chemotherapy (e.g., fluorouracil, capecitabine)
- ❑ Platinum-containing chemotherapy (e.g., cisplatin, carboplatin, oxaliplatin)

For non-small cell lung cancer, answer the following:

Does the patient have metastatic disease? ❑ **Yes** ❑ **No**

Will Cyramza be used in combination with docetaxel? ❑ **Yes** ❑ **No**

Has the patient's disease progressed on or after platinum-based chemotherapy (e.g., cisplatin, carboplatin, oxaliplatin)? ❑ **Yes** ❑ **No**

Does the patient have EGFR or ALK genomic tumor aberrations? ❑ **Yes** ❑ **No**

Has the patient had disease progression or intolerance to an approved targeted therapy (e.g., Tarceva, Gilotrif, Xalkori, Zykadia)? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following question:

Does the patient show evidence of progressive disease while on Cyramza therapy? ❑ **Yes** ❑ **No**

Cyramza® Prior Authorization Request Form (Page 2 of 2)

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.