OPTUMRx®

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:

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

Clinical Information:

Is Cyramza prescribed by or in consultation with an oncologist? ❑ **Yes** ❑ **No**
Is this request for continuation of prior Cyramza therapy? ❑ **Yes** ❑ **No**
Has the patient been on Cyramza within the past 120 days? ❑ **Yes** ❑ **No**

For colorectal cancer, also answer the following:

Does the patient have metastatic disease? ❑ **Yes** ❑ **No**
Select if the patient has had disease progression on or after prior therapy with the following:

- ❑ Bevacizumab
- ❑ Fluoropyrimidine
- ❑ Oxaliplatin
- ❑ Other: _____

Will Cyramza be used in combination with irinotecan or FOLFIRI (fluorouracil, leucovorin, and irinotecan) regimen? ❑ **Yes** ❑ **No**

For gastric cancer, also answer the following:

Select the patient's diagnosis:

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

Does the patient have locally advanced or metastatic disease? ❑ **Yes** ❑ **No**
Select if the patient has had disease progression on or after prior therapy with the following:

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

For non-small cell lung cancer, also 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**

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.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
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.