Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Cyramza
(ramucirumab)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Cyramza ☐ other (please specify): ICD10:

Dose: Frequency of therapy: Duration of therapy:

Is this a new start? ☐ Yes ☐ No Start date:
Will this medication be given concurrently with other agents? ☐ Yes ☐ No If yes, please specify:
What is your patient's current weight?

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
**Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Is the patient a candidate for home infusion? Yes ☐ No ☐
Does the physician have an in-office infusion site? Yes ☐ No ☐

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use:
☐ gastric cancer
☐ hepatocellular carcinoma (HCC)
☐ non-small cell lung cancer (NSCLC)
☐ colorectal cancer (CRC)
☐ gastro-esophageal junction (GEJ) adenocarcinoma
☐ other (please specify):

Clinical Information:
(if CRC) Does your patient have advanced or metastatic disease? ☐ Yes ☐ No
(if CRC) Will Cyramza be given in combination with irinotecan (Camptosar)? ☐ Yes ☐ No

(if gastric/gastro) Has/Had your patient only received ONE other treatment for this diagnosis before starting this drug? ☐ Yes ☐ No
(if only ONE other treatment) Did your patient have disease progression after receiving that first line chemotherapy? ☐ Yes ☐ No

(if CRC or HCC) Has your patient received any other treatment for this diagnosis before? ☐ Yes ☐ No
(if HCC) Will Cyramza be used as single agent therapy? ☐ Yes ☐ No
(if HCC) Does your patient have progressive disease? ☐ Yes ☐ No
(if HCC) Does your patient have unresectable disease or is not a transplant candidate? ☐ Yes ☐ No

(if not unresectable or is a transplant candidate) Is your patient's disease inoperable by performance status or comorbidity? ☐ Yes ☐ No

(if not inoperable) Does your patient have local disease or local disease with minimal extrahepatic disease only? ☐ Yes ☐ No

(if not local disease or local w/minimal extrahepatic) Does your patient have metastatic disease or extensive liver tumor burden? ☐ Yes ☐ No

(if not metastatic or extensive liver tumor burden) Does your patient have an alpha fetoprotein (AFP) level greater than or equal to 400 ng/mL? ☐ Yes ☐ No

(if AFP greater than or equal to 400) Has your patient been previously treated with sorafenib (Nexavar)? ☐ Yes ☐ No

(if NSCLC) Does your patient have metastatic disease? ☐ Yes ☐ No

(if NSCLC) Has your patient received any other treatment for this diagnosis before? ☐ Yes ☐ No

(if not previously treated) Does your patient have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) mutations? ☐ Yes ☐ No

(if not previous treatment) Is/Will the requested drug be(ing) used in combination with erlotinib (Tarceva)? ☐ Yes ☐ No

(if previous treatment) Will Cyramza be given in combination with docetaxel (Taxotere)? ☐ Yes ☐ No

(if previous treatment) Did your patient have disease progression on or following treatment with cisplatin or carboplatin? ☐ Yes ☐ No

(if previous treatment) Does your patient have one of the following gene mutations?

☐ EGFR-positive
☐ ALK (anaplastic lymphoma kinase)-positive
☐ neither
☐ unknown

(if EFGR-pos) Did your patient have disease progression while being treated with Tarceva or Gilotrif? ☐ Yes ☐ No

(if ALK-pos) Did your patient have disease progression while being treated with Xalkori or Zykadia? ☐ Yes ☐ No

Additional pertinent information: *(please include prior therapy, disease stage, performance status, relevant labs, and names/doses/admin schedule of any agents to be used concurrently).*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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