SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Cyramza® (Ramucirumab) Prior Authorization Form

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Drug Information

❑ Physician billing (HCPCS code:_____) ***Start Date (or date of next dose):*** _____
Dose: _____ ***Regimen:*** _____

Billing Provider Information

SoonerCare Provider ID: _____ ***Provider Name:*** _____

Provider Phone: _____ ***Provider Fax:*** _____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:*** _____

Prescriber Phone: _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

Criteria

For Initial Authorization (Initial approval will be for the duration of 6 months):

1. Please indicate the diagnosis and information:
   - ☐ Non-Small Cell Lung Cancer (NSCLC)
     - A. Will ramucirumab be used as subsequent therapy for metastatic disease after progression? Yes☐ No☐
     - B. Please provide member's ECOG performance status: ___
     - C. Will ramucirumab be used in combination with docetaxel? Yes☐ No☐
   - ☐ Colorectal Cancer
     - A. Will ramucirumab be used as subsequent therapy for metastatic disease after progression on or after prior therapy with bevacizumab, oxaliplatin, and a fluoropyrimidine? Yes☐ No☐
     - B. Will ramucirumab be used in combination with an irinotecan based regimen? Yes☐ No☐
   - ☐ Esophageal Cancer
     - A. Is diagnosis unresectable, locally advanced, recurrent or metastatic esophageal or esophagogastric junction adenocarcinoma ? Yes☐ No☐
     - B. Does member have a Karnofsky performance score greater than or equal to 60% or an ECOG performance score of 0 to 2? Yes☐ No☐
     - C. Will ramucirumab be used as a single-agent or in combination with paclitaxel? Yes☐ No☐
   - ☐ Gastric Cancer
     - A. Is member a surgical candidate? Yes☐ No☐
     - B. Does member have unresectable, locally advanced, recurrent or metastatic disease? Yes☐ No☐
     - C. Does member have a Karnofsky performance score greater than or equal to 60% or an ECOG performance score of 0 to 2? Yes☐ No☐
     - D. Will ramucirumab be used as a single-agent or in combination with paclitaxel? Yes☐ No☐
   - ☐ If answer is none of the above, please indicate diagnosis:_____

Additional Information: _____ _____
_____

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on ramucirumab? Yes____ No____
3. Has the member experienced adverse drug reactions related to ramucirumab therapy? Yes____ No____

If yes, please specify adverse reactions: _____
_____

Prescriber Signature: _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*