	Cyramza[®] (ramucirumab) Medication Precertification Request Page 1 of 2					Aetna Precertification NotificationPhone:1-866-752-7021FAX:1-888-267-3277For Medicare Advantage Part B:	
	(All fields must be completed and legible for precertification review.)				view.)	Phone: 1-866-503-0857 FAX: 1-844-268-7263	
Please indicate:	Start of treatment:					FAA. 1-044-200-7203	
	Continuation of the						
Precertification Re	equested By:			Phone	e:	Fax:	
A. PATIENT INFOR	MATION						
First Name:				Last Name:			
Address:				City:		State: ZIP:	
Home Phone:		Work Ph	none:	Cell Phone:			
DOB:	Allergies:				Email:		
	lbs_or	kgs	Height	: inches of	or cn	ns	
B. INSURANCE INF							
	#:			0			
Group #:				·	Carrier Name:		
C. PRESCRIBER IN	No If yes, provide I	D#:			L No If yes, p	provide ID #:	
First Name:	IFORMATION	ء ا	ast Name:		(Check (Dne): 🔲 M.D. 🗌 D.O. 🗌 N.P. [Πρα
Address:				City:	(0)/00// 0	State: ZIP:	
Phone:	Fax:	St	t Lic #:	NPI #:	DEA #:	UPIN:	
Provider Email:	T GAL		ffice Contact Nar		00,00	Phone:	
	one): Oncologist					T Hono.	
			-				
Place of Administr				Dispensing P	rovider/Pharma	cy: Patient Selected choice	
Self-administere	ed 🗌 Physician's	's Office				-	
				Physician'		Retail Pharmacy	
Outpatient Infus	sion Center Phone			-		Other:	
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Cyramza[®] (ramucirumab) Medication Precertification Request Page 2 of 2

Aetna Precertification Notification Phone: 1-866-752-7021 1-888-267-3277 FAX:

For Medicare Advantage Part B: Phone: 1-866-503-0857 FAX: 1-844-268-7263

(All fields must be completed and legible for precertification review.)	

Patient First Name	Patient Last Name	Patient Phone	Patient DOB						
G. CLINICAL INFORMATION (continued) – F	Required clinical information must be comp	leted in its <u>entirety</u> for all precertif	ication requests.						
Hepatocellular carcinoma									
What is the place in therapy in which the requested medication will be used? 🗌 First-line treatment 🔲 Subsequent treatment									
☐ Yes ☐ No Will the requested medication be used as a single agent?									
Yes No Unknown Does the patient have an alpha fetoprotein (AFP) of greater than or equal to 400 ng/mL?									
□ Non-small cell lung cancer (NSCLC)									
What is the clinical setting in which the requested drug will be used? 🗌 Advanced disease 📄 Recurrent disease 📄 Metastatic disease									
☐ Other (please specify):									
Yes No Will the requested medication be used in combination with erlotinib?									
\longrightarrow Yes \square No Will the requested medication be used in combination with docetaxel?									
What is the place in therapy in which the requested medication will be used? 🗌 First-line treatment 🗌 Subsequent treatment									
└────────────────────────────────────	n Does the patient have epidermal grov	vth factor receptor (EGFR) exo	n 19 deletion or L858R substitution						
	mutation positive disease?								
For Continuation Requests (clinical documentation required for all requests):									
Non-small cell lung cancer (NSCLC) only:									
Yes No Does the patient have T790M negative disease?									
\square Yes \square No Has the patient experienced disease progression or an unacceptable toxicity while on the current regimen?									
Yes No Has the patient experienced an unacceptable toxicity while on the current regimen?									
For all other continuation requests:									
Yes No Has the patient experienced disease progression or an unacceptable toxicity while on the current regimen?									
H. ACKNOWLEDGEMENT									
Request Completed By (Signature Requir	red):		Date: / /						
Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.									

The plan may request additional information or clarification, if needed, to evaluate requests.