PriorityHealth

Medical prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Cyramza® (ramucirumab)

Member

Last Name: ____________________ First Name: ____________________

ID #: ____________________ DOB: ______________ Gender: ______________

Primary Care Physician: ____________________

Requesting Physician: ____________________ Phone: ______________ Fax: ______________

Physician Address: ____

Physician NPI: ____________________ Contact Name: ____________________

Provider Signature: ____________________ Date: ______________

Product and Billing Information

☐ New request ☐ Continuation request

Drug product: ☒ Cyramza 100 mg/10 mL

Dose (mg/kg): ____________________

Frequency: ____________________

Weight: ____________________

Date of last dose: ____________________

Date of next dose: ____________________

Administration:

☐ Physician's Office

☐ Outpatient Infusion

Facility: ______________ NPI: ______________ Fax #: ______________

☐ Home infusion

Agency: ______________ NPI: ______________ Fax #: ______________

Billing:

☐ Physician Buy and Bill

☐ Facility Buy and Bill

☐ Specialty Pharmacy

Pharmacy: ______________ NPI: ______________ Fax #: ______________

ICD-10 Diagnosis Code(s): ____________________

Precertification Requirements

Before this drug is covered, the patient must have one of the following conditions:

☐ Advanced Gastric Cancer

☐ Gastro-Esophageal Junction Adenocarcinoma

☐ Metastatic Colorectal Cancer

☐ Non-Small Cell Lung Cancer

☐ Other – the patient's condition is: ____

Additional information

Requests for any condition not listed as covered require evidence of current medical literature that substantiates the drug's efficacy or that recognized oncology organizations generally accept the treatment for the condition.

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 07/2015

Last reviewed 07/2018