JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Cyramza

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office*

Drug Information:

*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_____ *Route of administration*_____
*Dosing frequency*_____

Send completed form to: Priority Partners Fax: 1-866-212-4756

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.jhhc.com

Criteria Questions:

1. What is the diagnosis?
   - ❑ Gastric adenocarcinoma
   - ❑ Gastro-esophageal junction (GEJ) adenocarcinoma
   - ❑ Esophageal adenocarcinoma
   - ❑ Non-small cell lung cancer (NSCLC)
   - ❑ Colorectal cancer
   - ❑ Hepatocellular carcinoma
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Is the patient currently receiving treatment with the requested medication? ❑ Yes ❑ No *If No, skip to #5*
4. Has the patient experienced disease progression or an unacceptable toxicity while receiving the requested drug/regimen? ❑ Yes ❑ No *No further questions*
5. What is the clinical setting in which the requested drug will be used?
   - ❑ As first-line treatment
   - ❑ As subsequent treatment
   - ❑ Other _____
6. Will the requested drug be used as any of the following?
   - ❑ as a single agent
   - ❑ in combination with paclitaxel
   - ❑ in combination with docetaxel
   - ❑ in combination with FOLFIRI (irinotecan, folinic acid, and 5-fluorouracil)
   - ❑ in combination with irinotecan
   - ❑ in combination with erlotinib
   - ❑ in combination with irinotecan with or without fluorouracil
   - ❑ Unkown

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Gastric Adenocarcinoma, Gastro-Esophageal Junction (GEJ) Adenocarcinoma, Esophageal Adenocarcinoma, Non-Small Cell Lung Cancer, Colorectal Cancer

7. How is the patient's disease classified?
   - ❑ Unresectable locally advanced disease
   - ❑ Recurrent disease
   - ❑ Metastatic disease
   - ❑ Advanced disease
   - ❑ Other _____
8. *If disease is classified as other and patient's diagnosis is gastric adenocarcinoma, gastro-esophageal junction adenocarcinoma or esophageal adenocarcinoma,* is the patient a surgical candidate? ❑ Yes ❑ No
9. *If patient's diagnosis is non-small cell lung cancer,* does the patient have epidermal growth factor receptor (EGFR) mutation positive disease? ❑ Yes ❑ No

Section B: Hepatocellular Cancer

10. Does the patient have an alpha fetoprotein (AFP) of greater than or equal to 400 ng/mL? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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