JOHNS HOPKINS MEDICINE JOHNS HOPKINS HEALTHCARE	Johns Hopkins HealthCare LLC **Pharmacy Public** **Medical Management Drug Policies**	*Policy Number*	MMDP067
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	Subject **Cyramza**	*Revision Date*	04/20/2022
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This document applies to the following Participating Organizations:

US Family Health Plan

Keywords: cyramza

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I. POLICY

Cyramza (ramucirumab) will require prior authorization for medical benefit coverage to ensure appropriate use. The process for initiating a prior authorization request can be found in policy PHARM 20.

II. POLICY CRITERIA

A. Cyramza may be approved for patients who meet the following:

1. Gastric, Gastro-esophageal Junction (GEJ), and Esophageal Adenocarcinoma
   a. Documentation has been submitted showing the following:
      I. Patient has a diagnosis of gastric, gastro-esophageal junction (GEJ), or esophageal adenocarcinoma, and one of the following:
         - Patient has unresectable locally advanced, recurrent or metastatic disease
         - Patient is not a surgical candidates
      II. Cyramza will be used in one of the following clinical situations:
         - Monotherapy
         - Combination with paclitaxel
         - Combination with irinotecan with or without fluorouracil
2. Non-Small Cell Lung Cancer (NSCLC)
   a. Documentation has been submitted showing the following:
      I. Patient has a diagnosis of recurrent, advanced or metastatic NSCLC
      II. Cyramza will be used in one of the following clinical situations:
         - Combination with docetaxel as subsequent therapy
         - Combination with erlotinib for EGFR mutation positive disease
3. Colorectal Cancer
   a. Documentation has been submitted showing the following:
      I. Patient has a diagnosis of advanced or metastatic colorectal cancer
      II. Cyramza will be used in one of the following clinical situations:
         - Combination with FOLFIRI (irinotecan, folinic acid, and 5-fluorouracil)
         - Combination with irinotecan

4. Hepatocellular Carcinoma
    a. Documentation has been submitted showing the following:
        I. Patient has a diagnosis of hepatocellular carcinoma with an alpha fetoprotein (AFP) of greater than or equal to 400 ng/mL
        II. Cyramza will be used as monotherapy for subsequent therapy

III. AUTHORIZATION PERIOD/LIMITATIONS

A. Initial approval will be limited to 12 months of therapy
B. Continuation of therapy may be approved in 12-month intervals with documentation showing the patient is continuing to tolerate the regimen and there has not been disease progression while on treatment

IV. EXCLUSIONS

A. Cyramza will not be covered for the following:
    1. Any indications or uses that are not FDA-approved, or guideline-supported

V. RECOMMENDED DOSAGE

Please refer to the FDA-approved prescribing information, or clinical guidelines, for indication-specific dosing details.

VI. CODES

Note: The following CPT/HCPCS codes are included below for informational purposes. Inclusion or exclusion of a CPT/HCPCS code(s) below does not signify or imply member coverage or provider reimbursement. The member's specific benefit plan determines coverage.

Medication	HCPCS/CPT Code
Injection, ramucirumab, 5 mg	J9308

VII. REFERENCES

1. Cyramza [prescribing information]. Indianapolis, IN: Eli Lilly and Company; June 2021.
2. The NCCN Drugs & Biologics Compendium® © 2022 National Comprehensive Cancer Network, Inc. https://www.nccn.org. Accessed March 25, 2022.

VIII. APPROVALS

Signature on file at JHHC

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