



MEDICARE FORM

AVASTIN™ (bevacizumab)

ALYMSYS™ (bevacizumab-maly)

MVASI™ (bevacizumab-awwb)

VEGZELMA® (bevacizumab-adcd)

ZIRABEV™ (bevacizumab-bvzr)

Medication Precertification Request

Page 1 of 3

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

For Medicare Advantage Part B:

FAX: 1-844-268-7263

PHONE: 1-866-503-0857

For other lines of business:

Please use other form

Note: Alymsys, Vegzelma, and Zirabev are non-preferred. The preferred products are Avastin and Mvasi.

Please indicate: Start of treatment: Start date ____ / ____ / ____ Continuation of therapy, Date of last treatment ____ / ____ / ____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:		Last Name:		DOB:	
Address:			City:		State: ZIP:
Home Phone:		Work Phone:		Cell Phone: Email:	
Patient Current Weight: ____ lbs or ____ kgs		Patient Height: ____ inches or ____ cms		Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____		Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Group #: _____		If yes, provide ID#: _____ Carrier Name: _____	
Insured: _____		Insured: _____	
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____		Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	

C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.	
Address:			City:		State: ZIP:
Phone:		Fax:		St Lic #: NPI #: DEA #: UPIN:	
Provider Email:			Office Contact Name:		Phone:
Specialty (Check one): <input type="checkbox"/> Oncologist <input type="checkbox"/> Ophthalmologist <input type="checkbox"/> Other: _____					

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:		Dispensing Provider/Pharmacy: Patient Selected choice	
<input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____		<input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____	

E. PRODUCT INFORMATION

Request is for: AVASTIN (bevacizumab) ALYMSYS™ (bevacizumab-maly) MVASI (bevacizumab-awwb)
 VEGZELMA (bevacizumab-adcd) ZIRABEV (bevacizumab-bvzr)

Dose: _____ Frequency: _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For Initiation Requests (clinical documentation required for all requests):

Ophthalmic disorders:

Yes No Is this request for Avastin treatment?
 ↳ Yes No Has the patient tried and failed treatment with Avastin due to a documented intolerable adverse event (e.g., rash, nausea, vomiting)?
 Yes No Was the adverse event unexpected and not attributed to the active ingredient as described in the prescribing information?

Please select the diagnosis:

Choroidal neovascularization (CNV) (including myopic choroidal neovascularization (mCNV), angioid streaks, choroiditis [including choroiditis secondary to ocular histoplasmosis], idiopathic degenerative myopia, retinal dystrophies, rubeosis iridis, pseudoxanthoma elasticum, and trauma)
 Diabetic macular edema
 Macular edema following retinal vein occlusion (RVO)
 Neovascular (wet) Age-Related Macular Degeneration (AMD)
 Neovascular glaucoma
 Polypoidal choroidal vasculopathy
 Proliferative diabetic retinopathy
 Retinopathy of prematurity

Continued on next page



MEDICARE FORM

AVASTIN™ (bevacizumab)

ALYMSYS™ (bevacizumab-maly)

MVASI™ (bevacizumab-awwb)

VEGZELMA® (bevacizumab-adcd)

ZIRABEV™ (bevacizumab-bvzr)

Medication Precertification Request

Page 2 of 3

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

For Medicare Advantage Part B:

FAX: 1-844-268-7263

PHONE: 1-866-503-0857

For other lines of business:

Please use other form

Note: Alymsys, Vegzelma, and Zirabev are non-preferred. The preferred products are Avastin and Mvasi.

Patient First Name	Patient Last Name	Patient Phone	Patient DOB
--------------------	-------------------	---------------	-------------

G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification

Oncology indications:

Note: Alymsys, Vegzelma, and Zirabev are non-preferred. The preferred products are Avastin and Mvasi.

Yes No Has the patient had prior therapy with Alymsys, Vegzelma, or Zirabev within the last 365 days?

Yes No Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply)

Avastin (bevacizumab) Mvasi (bevacizumab-awwb)

Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis? (select all that apply)

Avastin (bevacizumab) Mvasi (bevacizumab-awwb)

Yes No Is this request for Mvasi treatment?

Yes No Has the patient tried and failed treatment with Mvasi due to a documented intolerable adverse event (e.g., rash, nausea, vomiting)?

Yes No Was the adverse event unexpected and not attributed to the active ingredient as described in the prescribing information?

Please select the diagnosis:

Ampullary Adenocarcinoma

→ Please indicate the type of ampullary adenocarcinoma which applies to the patient's disease: Intestinal-type Other

Yes No Does the patient have progressive, unresectable, or metastatic disease?

→ Please select: progressive disease unresectable disease metastatic disease none of the above

Anaplastic glioma

Angiosarcoma

→ Yes No Will the requested medication be given as a single agent therapy?

Breast cancer

→ Yes No Does the patient have recurrent or metastatic disease?

→ Please select: recurrent disease metastatic disease none of the above

Cervical cancer

→ Yes No Does the patient have persistent, recurrent, or metastatic disease?

→ Please select: persistent disease recurrent disease metastatic disease none of the above

Colorectal cancer, including appendiceal adenocarcinoma and anal adenocarcinoma

Glioblastoma

Endometrial carcinoma

→ Yes No Does the patient have progressive, advanced, recurrent, or metastatic disease?

→ Please select: progressive disease advanced disease recurrent disease metastatic disease none of the above

Epithelial ovarian cancer (including carcinosarcoma [malignant mixed Müllerian tumors], clear cell carcinoma, mucinous carcinoma, endometrioid carcinoma, serous carcinoma, and malignant sex cord-stromal tumors)

Fallopian tube cancer

Hepatocellular carcinoma

→ Yes No Does the patient have unresectable or metastatic disease?

→ Please select: unresectable disease metastatic disease none of the above

Yes No Will the requested drug be used as initial treatment?

Yes No Will the requested medication be given in combination with atezolizumab (Tecentriq)?

Intracranial and spinal ependymoma (excludes subependymoma)

Limited and extensive brain metastases

Low-grade (WHO Grade 1 or 2) Glioma

Medulloblastoma

Meningiomas

Metastatic spine tumors

Non-squamous non-small cell lung cancer (NSCLC)

→ Yes No Does the patient have recurrent, advanced, metastatic, or unresectable disease?

→ Please select: recurrent disease advanced disease metastatic disease unresectable disease none of the above

Continued on next page.



MEDICARE FORM

AVASTIN™ (bevacizumab)

ALYMSYS™ (bevacizumab-maly)

MVASI™ (bevacizumab-awwb)

VEGZELMA® (bevacizumab-adcd)

ZIRABEV™ (bevacizumab-bvzr)

Medication Precertification Request

Page 3 of 3

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

For Medicare Advantage Part B:

FAX: 1-844-268-7263

PHONE: 1-866-503-0857

For other lines of business:

Please use other form

Note: Alymsys, Vegzelma, and Zirabev are non-preferred. The preferred products are Avastin and Mvasi.

Patient First Name	Patient Last Name	Patient Phone	Patient DOB
--------------------	-------------------	---------------	-------------

G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests

Mesothelioma

→ Please indicate the type of mesothelioma which applies to the patient's disease:

- malignant pleural mesothelioma malignant peritoneal mesothelioma pericardial mesothelioma tunica vaginalis testis mesothelioma
 other

Please indicate the place in therapy in which the requested drug will be used:

First-line treatment

→ Yes No Will the requested medication be given in combination with pemetrexed (Alimta) and either cisplatin (Platinol) or carboplatin (Paraplatin), followed by single-agent maintenance bevacizumab?

Yes No Does the patient have unresectable disease?

Subsequent treatment

→ Please select the requested regimen:

In combination with pemetrexed (Alimta) and either cisplatin (Platinol) or carboplatin (Paraplatin)

→ Yes No Has the patient received immunotherapy as first-line treatment?

In combination with atezolizumab (Tecentriq)

Other

Primary central nervous system lymphoma

Primary peritoneal cancer

Renal cell carcinoma

→ Yes No Does the patient have relapsed or stage IV disease? relapsed disease stage IV disease none of the above

Small bowel adenocarcinoma

Solitary fibrous tumor or hemangiopericytoma

→ Yes No Will the requested medication be given in combination with temozolomide (Temodar)?

Vaginal cancer

→ Yes No Does the patient have persistent, recurrent, or metastatic disease?

→ Please select: persistent disease recurrent disease metastatic disease none of the above

Uterine neoplasms

→ Yes No Does the patient have progressive, advanced, recurrent, or metastatic disease?

→ Please select: progressive disease advanced disease recurrent disease metastatic disease none of the above

Vulvar squamous cell carcinoma

→ Yes No Does the patient have unresectable locally advanced, recurrent, or metastatic disease?

→ Please select: unresectable locally advanced disease recurrent disease metastatic disease none of the above

For Continuation Requests (clinical documentation required for all requests):

Ophthalmic disorders:

Yes No Has the patient demonstrated a positive clinical response to therapy (e.g., improvement or maintenance in best corrected visual acuity [BCVA] or visual field, or a reduction in the rate of vision decline or the risk of more severe vision loss)?

Oncology indications:

Yes No Has the patient experienced an unacceptable toxicity or disease progression while on the current regimen?

H. ACKNOWLEDGEMENT

Request Completed By (Signature Required): _____ 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.