

MEDICARE FORM

AVASTIN[™] (bevacizumab) ALYMSYS[™] (bevacizumab-maly) AVZIVI[™] (bevacizumab-tnjn) MVASI[™] (bevacizumab-awwb) VEGZELMA[®] (bevacizumab-adcd) ZIRABEV[™] (bevacizumab-bvzr) **Medication Precertification Request**

For Medicare Advantage Part B:				
Phone:	1-866-503-0857	(TTY: <u>711</u>)		
FAX:	1-844-268-7263			

For other lines of business: Please use other form.

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

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Page	1	OT 3	

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

Please indicate: Start of treatment: Start date Precertification Requested By:	/ / [last treatmen Fax:	
A. PATIENT INFORMATION			e:	гах	
First Name:	Last Name:			DOB:	
Address:		City:		State:	ZIP:
Home Phone: Work Phone:		Cell Phone:		Email:	
	ntllaight incha		Allergies	Email.	
Patient Current Weight: lbs or kgs Patie	inche		Allergies:		
	Deep notiont have at				
Aetna Member ID #: Group #:	Does patient have other coverage?				
Insured:	Insured:				
Medicare: Yes No If yes, provide ID #:	Me	edicaid: 🗌 Yes	□ No If yes, prov	ride ID #:	
C. PRESCRIBER INFORMATION					
First Name:	Last Name:		(Check O	ne): 🗌 M.D. [□ D.O. □ N.P. □ P.A.
Address:		City:		State:	ZIP:
Phone: Fax:	St Lic #:	NPI #:	DEA #:	·	UPIN:
Provider Email:	Office Contact Name:			Phone:	
Specialty (Check one): 🗌 Oncologist 🔲 Ophthalm	ologist 🔲 Other:				
D. DISPENSING PROVIDER/ADMINISTRATION INFO	ORMATION				
Place of Administration:		Dispensing I	Provider/Pharmac	y: Patient Sel	ected choice
Self-administered Physician's Office		Physician	's Office	🗌 Retail Phari	macy
Outpatient Infusion Center Phone:		_ 🗌 Specialty	Pharmacy	Other	
Center Name:		– Name:			
Home Infusion Center Phone: Agency Name:					
Administration code(s) (CPT):					
Address: City: State:	סוד	Phone:		Fax:	
Phone: Fax:	ZIP	- TIN:		PIN:	
TIN: PIN:		NPI:			
NPI:		_			
E. PRODUCT INFORMATION					
	ALYMSYS™ (bevaci		AVZIVI™ (bev	-	-
	VEGZELMA (bevaciz				zr)
	Frequency:		HCPCS Code:		
F. DIAGNOSIS INFORMATION - Please indicate prima Primary ICD Code:	ary ICD code and speci _ Secondary ICD Cod			ICD Code:	
G. CLINICAL INFORMATION - Required clinical inform					
For Initiation Requests (clinical documentation required		ied in its <u>entirety</u> it		n 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					
Neovascular glaucoma Polypoidal choroidal vas					



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	(All fields must be completed a	nd legible for precertification review.)	
Patient First Name	Patient Last Name	Patient Phone	Patient DOB
	N <i>(continued)</i> – Required clinical info	rmation must be completed in its <u>er</u>	ntirety for all precertification requests
Oncology indications:			
Note: Alymsys, Avastin, Ava	zivi and Vegzelma are non-preferred. The	e preferred products are Mvasi and Zir	abev.
☐ Yes ☐ No Has the patie	nt had prior therapy with requested product	within the last 365 days?	
— — ·	nt had a trial and failure, intolerance, or cor bevacizumab-awwb) 🔲 Zirabev (bevacizu	, , , , , , , , , , , , , , , , , , , ,	lect all that apply)
Please explain if there are any patient's diagnosis? (select all	 other medical reason(s) that the patient ca that apply) 	annot use any of the following preferred p	products when indicated for the
☐ Mvasi (l	bevacizumab-awwb) 🔲 Zirabev (bevacizu	mab-bvzr)	
Please select the diagnosis:			
Ampullary Adenocarcinom			
	a e of ampullary adenocarcinoma which appli	es to the patient's disease.	type 🗍 Other
	ne patient have progressive, unresectable,		
	select: progressive disease unrese		none of the above
Anaplastic glioma			
🟳 Angiosarcoma			
	requested medication be given as a single	agent therapy?	
Breast cancer			
	ne patient have recurrent or metastatic dise		
Please	select: 🗌 recurrent disease 🗌 metastati	c disease [] none of the above	
Cervical cancer			
	ne patient have persistent, recurrent, or me		
	select: persistent disease recurrent		ne of the above
_	g appendiceal adenocarcinoma and anal ad	denocarcinoma	
Diffuse high grade gliomas			
Endometrial carcinoma			
	ne patient have progressive, advanced, rec	irrent or metastatic disease?	
	select: progressive disease advanced, ree		netastatic disease
Epithelial ovarian cancer (i	ncluding carcinosarcoma [malignant mixed ma, and malignant sex cord-stromal tumors	Müllerian tumors], clear cell carcinoma,	
Fallopian tube cancer			
Gastric cancer			
Hepatocellular carcinoma	a nationt have unreasonable or matastatic	20000	
	e patient have unresectable or metastatic select: unresectable disease metas		
	requested drug be used as initial treatment		
	requested medication be given in combina		
☐ IDH mutant astrocytoma (V			
	ndymoma (excludes subependymoma)		
Limited and extensive brain			
Low-grade (WHO Grade 1			
Medulloblastoma	,		
Meningiomas			

Continued on next page.



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AVASTIN[™] (bevacizumab) ALYMSYS[™] (bevacizumab-maly) AVZIVI[™] (bevacizumab-tnjn) MVASI[™] (bevacizumab-awwb) VEGZELMA[®] (bevacizumab-adcd) ZIRABEV[™] (bevacizumab-bvzr) Medication Precertification Request For Medicare Advantage Part B: Phone: <u>1-866-503-0857</u> (TTY: <u>711</u>) FAX: <u>1-844-268-7263</u>

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Patient First Name Patient Last Name Patient Phone Patient DOB G. CLINICAL INFORMATION (continuec)—Required clinical information must be completed in its <u>ontinue</u> for all precentification requests Mesothelioma maignant pleural mesothelioma = malignant perioneal mesothelioma = bricardial mesothelioma = bricardial mesothelioma unica vaginalis tests mesothelioma Billent First Name Please indicate the type of mesothelioma which applies to the patient's disease: maignant pleural mesothelioma brites Please indicate the type of mesothelioma which applies to the patient's disease: maignant pleural mesothelioma brites Please indicate the type of the requested medication be given in combination with permetroxed (Alima) and either cisplatin (Platinot) or carboplatin (Paraplatin) please select the requested regimen: please select: please select: please s		(All fields must be completed a	and legible for precertification revie	ew.)	
Image: Indicate the type of mescabelioma which applies to the patient's disease:	Patient First Name	Patient Last Name	Patient Phone	Patient DOB	
Image: Indicate the type of mescabelioma which applies to the patient's disease:					
Please indicate the type of mesothelioma which applies to the patient's disease: <pre></pre>		ontinued) – Required clinical infor	mation must be completed in its <u>e</u>	<u>entirety</u> for all precertification reques	sts
<pre> malignant placent mesothelioma malignant peritoreal mesothelioma pericardial mesothelioma tunica vaginalis testis mesothelioma </pre>	•				
difference				_	
Please indicate the place in therapy in which the requested drug will be used:		elioma 📋 malignant peritoneal mes	othelioma 📋 pericardial mesothe	elioma 📋 tunica vaginalis testis meso	othelioma
First-line treatment (Paraplatin), followed by single-agent maintenance bevacizumab? (Paraplatin), followed by single-agent maintenance bevacizumab? (Paraplatin), followed by single-agent maintenance bevacizumab? Subsequent treatment Please select the requested regimen: (In combination with pemetrexed (Alimta) and either cisplatin (Platinci) or carboplatin (Paraplatin) (In combination with atecvizumab (Tecentra) (Direct equested regimen: (Di					
Yes No Will the requested medication be given in combination with pemetrexed (Alimta) and either cisplatin (Platinol) or carbopiatin intemosi (Platinol) or carbopiatin (Platinol) or carbopiat	· · · · ·	herapy in which the requested drug v	will be used:		
(Paraplatin), followed by single-agent maintenance bevacizumab? □ Yes □ No Does the patient have unresectable disease? □ In combination with permetroxed (Alimta) and either cisplatin (Platinol) or carboplatin (Paraplatin) □ In combination with the permetroxed (Alimta) and either cisplatin (Platinol) or carboplatin (Paraplatin) □ In combination with the permetroxed (Alimta) and either cisplatin (Platinol) or carboplatin (Paraplatin) □ In combination with atezolizumab (Tecentriq) □ Other ○ Metastatic Spine tumors □ Neor-sequences non-small cell lung cancer (NSCLC) □ Yes □ No Does the patient have recurrent, advanced disease □ metastatic disease □ unresectable disease □ none of the above ○ Oligodentrogliona (WHO Grade 2 or 3) □ 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 □ Solitary fibrous tumor or hemangiopericytoma □ Yes □ No Does the patient have progressive, advanced, recurrent, or metastatic disease? □ Yes □ No Does the patient have persistent, recurrent, or metastatic disease? □ Yes □ No Does the patient have unresectable locally advanced, disease □ none of the above □ Yes □ No Does the patient have unresectable colly advanced disease □ none of the above □ Yes □ No Does the patient have unresectable locally advanced, re				····	l - tiu
				a) and either cisplatin (Platinol) of card	opiatin
Subsequent treatment Subsequent Subsequent treatment Subsequent treatment Subsequent treatment Subsequent treatment Subsequent treatment Subsequent S					
Please select the requested regimen:					
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Yes No Has the patient received immunotherapy as first-line treatment? In combination with atezolizumab (Tecentriq) Other Metastatic spine tumors No roots of central nervous system due to exposure to ionizing radiation Non-squamous non-small cell lung cancer (NSCLC) Please select: recurrent disease metastatic disease unressectable disease none of the above Objectend/oglioma (WHO Grade 2 or 3) Please select: recurrent disease metastatic disease stage IV disease none of the above Primary peritoneal cancer Renal cell carcinoma stage IV disease none of the above Small bowel adenocarcinoma Small bowel adenocarcinoma stage IV disease none of the above Small bowel adenocarcinoma Soliary librous tumor or hemangiopericytoma recurrent or metastatic disease none of the above Yes No Does the patient have progressive, advanced, recurrent, or metastatic disease? none of the above Yes No Does the patient have progressive, advanced, recurrent, or metastatic disease? none of the above Yes No Does the patient have progressive, advanced, recurrent, or metastatic disease? none of the above Yes No Does the patient have unresectable lo			atin (Platinol) or carboplatin (Parap	platin)	
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□ cercrosis of central nervous system due to exposure to ionizing radiation □ Non-squamous non-small cell lung cancer (NSCLC) □ Constraint of the patient have recurrent, advanced, metastatic, or unresectable disease? □ Please select: □ recurrent disease □ Oligodendroginioma (WHO Grade 2 or 3) □ Primary central nervous system lymphoma □ Primary central nervous system lymphoma □ Primary central nervous system lymphoma □ Solitary fibrous tumor or hemangiopericytoma □ Solitary fibrous tumor or hemangiopericytoma □ Yes □ No Does the patient have progressive, advanced, recurrent, or metastatic disease? □ Ves □ No Does the patient have progressive, advanced, recurrent, or metastatic disease? □ Yes □ No Does the patient have progressive disease □ recurrent disease □ none of the above □ Yaginal cancer □ Yes □ No Does the patient have progressive disease □ recurrent disease? □ Yes □ No Does the patient have progressive disease □ recurrent disease? □ Yes □ No Does the patient have unresectable locally advanced, recurrent, or metastatic disease? □ Yes □ No Does the patient have unresectable locally advanced, recurrent, or metastatic disease? □ Yes □ No Does the patient have unresectable locally advanced, recurrent, or metastatic disease? □ Yes □ No Does the patient have unresectable locally advanced, recurrent disease □ none of the above	Other				
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Solitary fibrous tumor or hemangiopericytoma Solitary fibrous tumor oresectable local	_			—	
Yes No Will the requested medication be given in combination with temozolomide (Temodar)? Uterine neoplasms Yes No Does the patient have progressive, advanced, recurrent, or metastatic disease? Yes Yes No Does the patient have persistent, recurrent, or metastatic disease Yes No Does the patient have persistent, recurrent, or metastatic disease Yes No Does the patient have persistent, recurrent, or metastatic disease Please select: persistent disease recurrent disease metastatic disease? Please select: persistent disease recurrent disease metastatic disease? Please select: ulterine requests (clinical documentation required for all requests): Ophthalmic disorders: Pres 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 H. ACKNOWLEDGEMENT Request Completed By (Signature Required): /	—	giopericytoma			
Uterine neoplasms ↓ Yes No Does the patient have progressive, advanced, recurrent, or metastatic disease? ↓ Vaginal cancer ↓ Please select:] progressive disease] advanced disease] recurrent disease] metastatic disease] none of the above ↓ Ves No Does the patient have persistent, recurrent, or metastatic disease? ↓ Ves No Does the patient have unresectable locally advanced, recurrent, or metastatic disease? ↓ Vuvar squamous cell carcinoma ↓ Yes No ↓ Ves No Does the patient have unresectable locally advanced, recurrent, or metastatic disease? ↓ Ves No Does the patient have unresectable locally advanced, recurrent disease metastatic disease? ↓ Ves No Does the patient have unresectable locally advanced, recurrent disease metastatic disease? ↓ Ves No Does the patient have unresectable locally advanced disease recurrent disease? Please select: unresectable locally advanced disease recurrent disease metastatic disease? Opthalmic disorders: 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?			ation with temozolomide (Temodar	r)?	
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	H. ACKNOWLEDGEMENT				
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	Request Completed By (Signat	ure Required):		Date:	<u>/ / </u>
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.				or the purpose of misleading, comm	its a fraudulent

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