aetna®

MEDICARE FORM

AVASTIN™ (bevacizumab)
ALYMSYS™ (bevacizumab-maly)
MVASI™ (bevacizumab-awwb)
VEGZELMA® (bevacizumab-adcd)
ZIRABEV™ (bevacizumab-bvzr)
Medication Precertification Request

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

For Illinois MMP:
FAX: 1-855-320-8445
PHONE: 1-866-600-2139

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 #: _____
Group #: _____
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:		Last Name:		*(Check One):* ☐ 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** ☐ **Ophthalmologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:

☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*

☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ 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

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

For Illinois MMP:
FAX: 1-855-320-8445
PHONE: 1-866-600-2139

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.

aetna®

MEDICARE FORM

AVASTIN™ (bevacizumab)
ALYMSYS™ (bevacizumab-maly)
MVASI™ (bevacizumab-awwb)
VEGZELMA® (bevacizumab-adcd)
ZIRABEV™ (bevacizumab-bvzr)
Medication Precertification Request

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

For Illinois MMP:
FAX: 1-855-320-8445
PHONE: 1-866-600-2139

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.