



Fax completed form to: (855) 840-1678
 If this is an URGENT request, please call (800) 882-4462
 (800.88.CIGNA)

Avastin (bevacizumab)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:		* Date of Birth:
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		
Urgency:					
<input type="checkbox"/> Standard <input type="checkbox"/> Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)					
Medication Requested: <input type="checkbox"/> Avastin Is this a new start? <input type="checkbox"/> Yes <input type="checkbox"/> No Start date: _____ Dose: _____ Frequency of therapy: _____ Duration of therapy: _____ Will this medication be given concurrently with other agents? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify: _____ What is your patient's current weight? _____ ICD10: _____					
Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Other (please specify): _____ **Cigna's nationally preferred specialty pharmacy					
<i>**Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 Century Center Pkwy, Memphis, TN 38134-8822 NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557</i>					
Facility and/or doctor dispensing and administering medication:					
Facility Name:		State:		Tax ID#:	
Address (City, State, Zip Code):					
NOTE: Per some Cigna plans, infusion of medication <i>MUST</i> occur in the lowest cost, medically appropriate setting					
Is this infusion occurring in a facility affiliated with hospital outpatient setting? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes- Is this patient a candidate for re-direction to an alternate setting (such as AIS, MDO, home) with assistance of a Specialty Care Option Case Manager? <input type="checkbox"/> Yes <input type="checkbox"/> No (provide medical necessity rationale):					
Is your patient a candidate for home infusion? Yes <input type="checkbox"/> No <input type="checkbox"/> Does the physician have an in-office infusion site? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Diagnosis:					
<input type="checkbox"/> AIDS-related Kaposi sarcoma (KS) <input type="checkbox"/> fallopian tube cancer <input type="checkbox"/> angiosarcoma <input type="checkbox"/> granulosa cell ovarian cancer <input type="checkbox"/> breast cancer <input type="checkbox"/> non-small cell lung cancer (NSCLC) <input type="checkbox"/> cervical cancer (carcinoma of the cervix) <input type="checkbox"/> pleural mesothelioma <input type="checkbox"/> CNS/brain tumor <input type="checkbox"/> primary peritoneal cancer <input type="checkbox"/> colon or rectal cancer (colorectal cancer, CRC) <input type="checkbox"/> renal cell cancer (RCC) <input type="checkbox"/> endometrial cancer <input type="checkbox"/> epithelial ovarian cancer (including serous, mucinous, endometrioid, clear-cell, Brenner or transitional cell) <input type="checkbox"/> solitary fibrous tumor/hemangiopericytoma <input type="checkbox"/> vulvar squamous cell carcinoma <input type="checkbox"/> hepatocellular carcinoma (HCC)					

other (please specify):

(if CNS/brain tumor) What is your patient's diagnosis?

- anaplastic glioma (including anaplastic astrocytoma, anaplastic oligodendroglioma and anaplastic oligoastrocytoma)
- central nervous system (CNS) brain metastases
- central nervous system (CNS) meningioma
- ependymoma
- glioblastoma (including glioblastoma multiforme)
- leptomeningeal metastases
- medulloblastoma
- primary central nervous system (CNS) lymphoma
- subependymoma
- spine tumor
- other (please specify):

(if other to either question above) Is this use related to chemotherapy or oncology (cancer)?

Yes No

Clinical Information

(if NSCLC) Does your patient have non-squamous cell NSCLC?

Yes No

(if NSCLC) Does your patient have unresectable, locally advanced, recurrent, or metastatic disease?

Yes No

(if NSCLC) Is the drug requested being given as first-line therapy?

Yes

No, patient has tried other drugs before for this diagnosis

Unknown

(if first-line) Will the drug requested be given in combination with carboplatin and paclitaxel?

Yes No

(if breast) Does your patient have recurrent or metastatic disease?

Yes No

(if breast) Will the drug requested be used in combination with weekly paclitaxel?

Yes No

(if breast) Is your patient's breast cancer HER2-negative?

Yes No

(if breast) Is your patient's breast cancer hormone-receptor positive or hormone-receptor negative?

positive negative unknown

(if positive) Did your patient fail endocrine therapy?

Yes No

(if no) Does your patient have symptomatic visceral (lung, liver, pancreas, intestine) disease or visceral crisis?

Yes No

(if pleural mesothelioma) Will the drug requested be used in combination with Alimta (pemetrexed) and EITHER cisplatin or Paraplatin (carboplatin)?

Yes No

(if pleural mesothelioma) What is your patient's stage?

stage 1 (I)-stage 3a (IIIa)

stage 3b (IIIb)-stage 4 (IV)

unknown

(if stage 1-3a) Does your patient have unresectable disease?

Yes No

(if not unresectable OR unknown stage) Does your patient have medically inoperable tumors?

Yes No

(if inoperable tumors) What is your patient performance status?

PS 0-2

PS 3-4

unknown

(if cervical) Does your patient have persistent, recurrent, or metastatic disease?

Yes No

(if cervical) Will the drug requested be used in combination with paclitaxel and either cisplatin or carboplatin OR paclitaxel and topotecan (Hycamtin)?

Yes No

(if CRC or spine tumor) Does your patient have metastatic disease?

Yes No

(if CRC) How is the drug requested being used in your patient's treatment?

in combination with a fluorouracil (Adrucil, 5-FU) based chemotherapy regimen

in combination with fluoropyrimidine-irinotecan (Camptosar)- OR fluoropyrimidine-oxaliplatin-based chemotherapy

other

(if in combo with 5-FU chemo) Is the drug requested being used as a first or second-line therapy?

Yes No

(if in combo with fluoropyrimidine-irinotecan- or fluoropyrimidine-oxaliplatin-based chemo) Did your patient have disease progression while on a first-line bevacizumab (Avastin, Mvasi, Zirabev)-containing regimen?

Yes No

(if endometrial) Which of the following best describes the requested drug's role in your patient's therapy?

for disease progression after failure of first-line therapy

for the treatment of advanced or recurrent disease

other

(if advanced or recurrent) Will the drug requested be used in combination with carboplatin and paclitaxel?

Yes No

(if HCC) Does your patient have unresectable or metastatic disease?

Yes No

(if HCC) Will the requested drug be used in combination with Tecentriq (atezolizumab)?

Yes No

(if HCC) Has the patient received prior systemic therapy for this diagnosis in the past?

Yes No

(if RCC) Does your patient have relapsed or metastatic disease? Yes No

(if RCC) What is the histology of the disease?
 non-clear cell
 predominantly clear cell
 other

(if non-clear) Does your patient have advanced papillary renal cell carcinoma [RCC] (including hereditary leiomyomatosis and renal cell cancer [HLRCC])? Yes No

(if yes) Will the drug requested be used in combination with Afinitor (everolimus) or Tarceva (erlotinib)? Yes No

(if predominant clear cell) Which best describes how the drug requested will be used?
 as first-line therapy
 following disease progression while on previous therapy
 neither of the above

(if non-clear or after disease progression with clear cell) Will the drug requested be used as single-agent therapy? Yes No

(if predominant clear cell and first-line) Will the drug requested be used in combination with Intron-A? Yes No

(if granulosa cell ovarian) Does your patient have relapsed disease? Yes No

(if angiosarcoma, CNS brain mets, endometrial, ependymoma, granulosa cell ovarian, lep mets, medulloblastoma, primary CNS lymphoma, spine tumor) Will the drug requested be used as single-agent therapy? Yes No

(if anaplastic glioma or glioblastoma) Does your patient have recurrent disease? Yes No

(if ependymoma) Does the patient have progressive disease? Yes No

(if CNS meningioma) Does your patient have recurrent or progressive disease? Yes No

(if CNS meningioma) Is the lesion surgically inaccessible (meaning that standard surgical techniques can't reach it)? Yes No

(if CNS meningioma) Is radiation a possible option? Yes No

(if CNS brain mets, lep mets, or spine tumor) Is the drug requested being given to control symptoms? Yes No

(if solitary fibrous tumor/hemangiopericytoma) Will the drug requested be used in combination with Temodar (temozolomide)? Yes No

(if epithelial ovarian, fallopian tube, peritoneal) Is your patient's cancer associated with homologous recombination deficiency (HRD) positive status? Yes No

(if HRD positive) Did the patient have gene testing showing genomic instability AND/OR a deleterious or suspected deleterious BRCA mutation? Yes No

(if yes) Has your patient had a complete or partial response to first-line platinum-based chemotherapy (carboplatin or cisplatin)? Yes No

(if complete or partial response) Will the requested drug be used for first-line maintenance treatment? Yes No

(if first-line maintenance) Does your patient have advanced disease? Yes No

(if advanced disease) Will the requested drug be used in combination with Lynparza (olaparib)? Yes No

(if epithelial ovarian, fallopian tube, or primary peritoneal and not to ANY of the previous 6 questions) Does your patient have stage III or IV disease? Yes No

(if stage III or IV) Has your patient had surgical resection? Yes No

(if resection) Will/Was the drug requested used in combination with carboplatin and paclitaxel, followed by single-agent therapy with bevacizumab (Avastin, Mvasi, Zirabev)? Yes No

(if no to any of the previous 3 questions) Does your patient have persistent or recurrent disease? Yes No

(if persistent or recurrent) Has your patient been treated with bevacizumab (Avastin, Mvasi, Zirabev) before? Yes No

(if treated with bevacizumab before) Is your patient currently on bevacizumab (Avastin, Mvasi, or Zirabev) for this diagnosis? Yes No

(if no bevacizumab before OR currently on) Will the drug requested be used as single-agent therapy? Yes No

(if not single agent) Was your patient previously treated with carboplatin or cisplatin (platinum therapy)?
 Yes, and patient was platinum-refractory (no response with progression during treatment)
 Yes, and patient was platinum-resistant (showed initial response to chemotherapy but relapsed within 6 months of last round of chemotherapy)
 Yes, and patient was platinum-sensitive
 No, patient was not treated with platinum therapy
 Unknown

(if platinum-sensitive) Will the drug requested be used in combination with EITHER paclitaxel and carboplatin OR gemcitabine (Gemzar) and carboplatin? Yes No

(if platinum-resistant) Will the drug requested be used in combination with liposomal doxorubicin (Doxil or Lipodox), paclitaxel OR topotecan (Hycamtin)? Yes No

(if epithelial ovarian) Which type of epithelial tumor does your patient have?
 serous or endometrioid
 mucinous
 clear cell
 unknown or other

(if serous/endometrioid or mucinous) Will the drug requested be used as adjuvant therapy? Yes No

(if mucinous and NOT adjuvant) Does your patient have persistent or recurrent disease? Yes No

(if serous/endometrioid) What is the tumor grade?

- grade 1
- grade 2
- grade 3
- unknown

(if serous/endometrioid, mucinous, or granulosa cell) What is your patient's cancer stage?

- Stage 1 (I)
- Stage 2 (II)
- Stage 3 (III)
- Stage 4 (IV)
- unknown

(if serous/endometrioid, adjuvant, and stage II/III/IV) Will the drug requested be used in combination with carboplatin and paclitaxel? Yes No

(if mucinous, adjuvant and stage II/III/IV) Is the drug requested being used as any of the following?

- as combination therapy with carboplatin and paclitaxel
- as combination therapy with capecitabine (Xeloda) and oxaliplatin
- as combination therapy with fluorouracil (Acrucil, 5-FU), leucovorin, and oxaliplatin
- none of the above

(if mucinous and persistent or recurrent) Is the drug requested being used as any of the following?

- as combination therapy with fluorouracil (Acrucil, 5-FU), leucovorin, and oxaliplatin
- as combination therapy with capecitabine (Xeloda) and oxaliplatin
- neither of the above

(if vulvar squamous cell carcinoma) Will the drug requested be used in combination with paclitaxel and EITHER cisplatin or Paraplatin (carboplatin)? Yes No

(if vulvar squamous cell carcinoma) Which best describes your patient's diagnosis?

- unresectable locally advanced disease with residual tumor at primary site
- locally advanced disease with positive margins following resection
- as primary treatment for metastatic disease beyond the pelvis
- for isolated groin/pelvic recurrence if prior external beam radiation therapy (EBRT)
- for clinical nodal or distant recurrence with multiple pelvic nodes, distant metastasis, or prior pelvic EBRT
- other

Is this a new start or continuation of therapy with the requested drug? new start continuation of therapy

(if new start) Does your patient have documentation of trying Mvasi (bevacizumab-awwb) AND Zirabev (bevacizumab-bvzr)? Yes No

Additional pertinent information: (including disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently)

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature: _____ **Date:** _____

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