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:
☐ Standard ☐ 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: ☐ Avastin Is this a new start? ☐ Yes ☐ No Start date:
Dose: Frequency of therapy: Duration of therapy:
Will this medication be given concurrently with other agents? ☐ Yes ☐ No If yes, please specify:
What is your patient's current weight? ICD10:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

*****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*

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 MUST occur in the lowest cost, medically appropriate setting*
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Is this infusion occurring in a facility affiliated with hospital outpatient setting? ☐ Yes ☐ 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? ☐ Yes ☐ No (provide medical necessity rationale):

Is your patient a candidate for home infusion? Yes ☐ No ☐
Does the physician have an in-office infusion site? Yes ☐ No ☐

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? ☐ Yes ☐ No

Diagnosis:
☐ AIDS-related Kaposi sarcoma (KS)
☐ Ampullary adenocarcinoma
☐ angiosarcoma
☐ cervical cancer (carcinoma of the cervix)
☐ colon or rectal cancer (colorectal cancer, CRC)
☐ non-small cell lung cancer (NSCLC)
☐ endometrial cancer
☐ epithelial ovarian cancer (including serous, mucinous, endometrioid, clear-cell, Brenner or transitional cell)
☐ hepatocellular carcinoma (HCC)
☐ small bowel adenocarcinoma
☐ other (please specify):
☐ fallopian tube cancer
☐ granulosa cell ovarian cancer
☐ CNS/brain tumor
☐ pleural mesothelioma
☐ primary peritoneal cancer
☐ radiation necrosis and uncontrolled cerebral edema
☐ renal cell cancer (RCC)
☐ solitary fibrous tumor/hemangiopericytoma
☐ vulvar squamous cell carcinoma

(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 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, radiation necrosis and uncontrolled cerebral edema) 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 or paclitaxel
☐ as combination therapy with capecitabine (Xeloda) and oxaliplatin
☐ as combination therapy with fluorouracil (Adrucil, 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 (Adrucil, 5-FU), leucovorin, and oxaliplatin
☐ as combination therapy with capecitabine (Xeloda) and oxaliplatin
☐ neither of the above

(if small bowel adenocarcinoma) Will this drug be used in combination with either a Xeloda (capecitabine) or a 5-fluorouracil (5-FU) regimen? Yes ☐ No ☐

(if small bowel adenocarcinoma) Does the patient have advanced or metastatic disease? Yes ☐ No ☐

(if small bowel adenocarcinoma) Will the patient be using Avastin as initial therapy? Yes ☐ No ☐

(if no) Will the patient be using Avastin as subsequent therapy in patients who previously received initial therapy with Opdivo (nivolumab)? Yes ☐ No ☐

(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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