



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:		
<b>Urgency:</b> <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)					
<b>Medication Requested:</b> <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:					
<b>Where will this medication be obtained?</b> <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					
**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					
<b>Facility and/or doctor dispensing and administering medication:</b> Facility Name: State: Tax ID#: Address (City, State, Zip Code):					
<b>Is your patient a candidate for home infusion?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Does the physician have an in-office infusion site?</b> 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					
<b>Diagnosis:</b> <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) <input type="checkbox"/> other (please specify):  (if CNS/brain tumor) What is your patient's diagnosis? <input type="checkbox"/> anaplastic glioma (including anaplastic astrocytoma, anaplastic oligodendroglioma and anaplastic oligoastrocytoma) <input type="checkbox"/> central nervous system (CNS) brain metastases <input type="checkbox"/> central nervous system (CNS) meningioma <input type="checkbox"/> ependymoma <input type="checkbox"/> 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 Targev (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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