Medical drug benefit
Prior authorization request

Avastin, Mvasi or Zirabev

Version20 Effective: 07/26/2023

WellSense HEALTH PLAN

Phone: 877-417-1839 (NH Medicaid)
Fax: 866-539-7185

* Some plans might not accept this form for Medicare or Medicaid requests

This form is being used for:	
Check if Expedited Review/Urgent Request:	☐ (In checking this box, I attest to the fact that this request meets the definition and criteria for expedited review and is an urgent request.)

1. Patient information	
Patient Name:	DOB:
Member ID #:	

2. Prescriber information	
Prescribing Clinician:	Phone #:
Specialty:	Secure Fax #:
NPI #:	DEA/xDEA:
Prescriber Point of Contact Name (POC) (if different than provider):	
POC Phone #:	POC Secure Fax #:
POC Email (not required):	
Prescribing Clinician or Authorized Representative Signature:	Date:

3. Drug request	
Please select the drug you are requesting (select **one**):	
☐ Avastin	☐ Mvasi
☐ Zirabev	*Continued on next page*

4. Requested dosing

Please document the requested dosing:

5. Please select the appropriate condition:

Please select the appropriate condition (select ONE):

☐ Neurovascular or Vascular Ophthalmic Conditions (proceed to Q16)

☐ Oncology conditions (For Avastin, proceed to Q6, Mvasi or Zirabev, proceed to Q7)

6. If the selected drug is Avastin

If the selected drug is Avastin, please choose **all** of the following that apply: (Proceed to Q7)

☐ Member has tried Mvasi or Zirabev or both

☐ Member cannot continue use with Mvasi or Zirabev due to a formulation difference in the INACTIVE ingredient(s) that would result in a significant allergy or adverse effect (e.g., differences in stabilizing agent, buffering agent, and/or surfactant)

☐ Member is currently taking the requested agent

☐ Other clinical information (please specify):

7. Diagnosis

What is the diagnosis the requested medication is being used to treat: (select ONE)

☐ Breast cancer (proceed to Q11)

☐ Central nervous system tumors (proceed to Q8)

☐ Cervical cancer (proceed to Q14)

☐ Colon or rectal cancer (proceed to Q12)

☐ Endometrial carcinoma (proceed to Q13)

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☐ Hepatocellular Carcinoma (HCC) (proceed to Q12)

☐ Malignant pleural mesothelioma (proceed to Q12)

☐ Non-small cell lung cancer (NSCLC) (proceed to Q10)

☐ Ovarian, Fallopian Tube, or Primary Peritoneal Cancer (proceed to Q15)

☐ Renal cell cancer (proceed to Q14)

☐ Small bowel adenocarcinoma (proceed to Q12)

☐ Soft tissue sarcoma (proceed to Q9)

☐ Vulvar cancer (squamous cell carcinoma) (proceed to Q12)

☐ Other, please indicate diagnosis below and include supporting clinical documentation for use in this indication and attached applicable chart notes in faxed request detailing member's clinical status, dose and dates of all previous therapies and outcomes, proper succession of therapies that have been tried and failed and any related lab work and test results.

8. If the selected diagnosis is Central Nervous System Tumors

Does the member have one of the following? (Proceed to Q13)

☐ Anaplastic gliomas

☐ Glioblastoma

☐ Intracranial and spinal ependymoma (excluding subependymoma) in ≥ 18 years of age

☐ Meningiomas

☐ Other (please specify):

9. If the selected diagnosis is Soft Tissue Sarcoma:

Does the member have one of the following? Please select ONE of the following (proceed to Q15)

☐ Angiosarcoma	☐ Solitary fibrous tumor

☐ Other, please specify:

10. If the selected diagnosis is Non-small cell Lung Cancer (NSCLC):

Please choose **all** of the following that apply:

☐ The NSCLC tumor is positive for epidermal growth factor receptor (EGFR) mutation and bevacizumab is used in combination with erlotinib (Proceed to Q14)

☐ Member has previously received targeted drug therapy for an actionable mutation (Proceed to Q14)

☐ The NSCLC tumor is negative or unknown for actionable mutations (proceed to Q12)

11. If the selected diagnosis is breast cancer

Does the member have recurrent or metastatic human epidermal growth factor receptor 2 (HER2)-negative breast cancer (Proceed to Q12):

☐ Yes

☐ No

12. Please choose ALL of the following that apply

Please choose **all** of the following that apply:

☐ Bevacizumab is used in combination with a chemotherapy regimen	☐ Bevacizumab is not being used for adjuvant treatment
☐ Bevacizumab is used in combination with Tecentriq	☐ Bevacizumab is used as initial therapy in combination with other systemic therapies
☐ Bevacizumab is used as subsequent therapy	☐ Bevacizumab is used in combination with paclitaxel
☐ Bevacizumab is being used as a single agent for maintenance therapy after the member has received combination chemotherapy regimen	

13. If the selected diagnosis is Central Nervous System Tumor, Hepatocellular Carcnoma or Endometrial Carcinoma:

Please choose **all** of the following that apply:

☐ Member had tried at least one previous therapy with temozolamide, etoposide, carmustine or radiotherapy

☐ Member has not received prior systemic therapy

☐ Member has progressed on prior chemotherapy

14. Type of disease

Please choose **one** of the following that apply:

☐ Advanced disease	☐ Locally advanced disease
☐ Metastatic disease	☐ Recurrent disease
☐ Unresectable disease	☐ Other, please specify:

15. Specialty of the prescriber

Please indicate what specialty the prescriber is (select any that apply):

☐ Oncologist	

☐ Other (please indicate what specialty below):

16. Initial or continuing therapy

Is the request for initial or continuing therapy?

☐ Initial (Proceed to Q18)

☐ Continuation (Proceed to Q17)

17. For continuing therapy

For continuing therapy, has the member;s clinical condition improved or stabilized (e.g. decreased progression) without treatment-related adverse events?

☐ Yes

☐ No

18. HCPCS Codes

Please document the applicable HCPCS codes (e.g. J codes or Q codes) being requested, including the number of units and number of visits *(using the space below):*

☐ HCPCS / Qcodes:

☐ Number of units:

☐ Number of visits:

Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form. Providers may attach any additional data relevant to medical necessity criteria.