Avastin, Alymsys, Avzivi, Mvasi, Vegzelma, Zirabev

CareFirst Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

What product is being requested?
❒ Avastin ❒ Alymsys ❒ Avzivi ❒ Mvasi ❒ Vegzlema ❒ Zirabev

What is the ICD-10 code? _____

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

 Avastin and Bevacizumab Biosimilar MR CareFirst C26636-D, SGM 1891-A – 06/2025.

Exception Criteria Questions:

A. What drug is being prescribed?

❑ Mvasi, *Skip to Clinical Criteria Questions*
❑ Alymsys, *Continue to Question B*
❑ Zirabev, *Skip to Clinical Criteria Questions*
❑ Vegzelma, *Continue to Question B*
❑ Avastin, *Continue to Question B*

B. Is the product being requested for the treatment of an oncology indication?

❒ Yes, *Continue to Question C*

❒ No, *Skip to Clinical Criteria Questions*

C. The preferred products for your patient's health plan are Mvasi and Zirabev. Can the patient's treatment be switched to one of the preferred products?

❒ Yes, Mvasi, *Skip to Clinical Criteria Questions*

❒ Yes Zirabev, *Skip to Clinical Criteria Questions*

❒ No, *Continue to Question D*

D. Did the patient have a documented intolerable adverse event to both preferred products (Mvasi and Zirabev)? ***ACTION REQUIRED****: If 'yes', attach supporting chart note(s).*

❒ Yes, *Continue to Question E*

❒ No, *Continue to Question F*

E. Was the documented intolerable adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the reference product and biosimilar products)? ***ACTION REQUIRED****: If 'no', attach supporting chart note(s)*

❒ Yes, *Continue to Question F*

❒ No, *Skip to Clinical Criteria Questions*

F. Did the patient have a documented inadequate response to both preferred products (Mvasi and Zirabev)? ***ACTION REQUIRED****: If 'yes', attach supporting chart note(s)*

❒ Yes, *Skip to Clinical Criteria Questions*

❒ No *Continue to Question G*

G. Does the patient have a contraindication to both preferred products (Mvasi and Zirabev)? ***ACTION REQUIRED****: If 'yes', attach supporting chart note(s)*

❒ Yes, *Continue to Clinical Criteria Questions*
❒ No, *Continue to Clinical Criteria Questions*

Clinical Criteria Questions:

1. What is the diagnosis?

❒ Diabetic Macular Edema, *Continue to 26*
❒ Neovascular (Wet) Age-Related Macular Degeneration, *Continue to 26*
❒ Macular Edema Following Retinal Vein Occlusion, *Continue to 26*
❒ Proliferative Diabetic Retinopathy, *Continue to 26*
❒ Choroidal Neovascularization (including myopic choroidal neovascularization, angioid streaks, choroiditis [including choroiditis secondary to ocular histoplasmosis], idiopathic degenerative myopia, retinal dystrophies, rubeosis iridis, pseudoxanthoma elasticum, and trauma), *Continue to 26*
❒ Neovascular Glaucoma, *Continue to 26*
❒ Retinopathy of Prematurity, *Continue to 26*
❒ Polypoidal Choroidal Vasculopathy, *Continue to 26*
❒ Colon cancer, *Continue to 2*
❒ Rectal cancer, *Continue to 2*
❒ Appendiceal adenocarcinoma, *Continue to 2*
❒ Anal adenocarcinoma, *Continue to 2*
❒ Non-squamous non-small cell lung cancer (NSCLC), *Continue to 2*
❒ Circumscribed glioma, *Continue to 2*
❒ Diffuse high grade and high grade gliomas, *Continue to 2*
❒ Glioblastoma, *Continue to 2*
❒ IDH mutant astrocytoma (WHO Grade 2, 3 or 4), *Continue to 2*
❒ Oligodendroglioma (WHO Grade 2 or 3), *Continue to 2*
❒ Intracranial and spinal ependymoma (excludes subependymoma), *Continue to 2*
❒ Medulloblastoma, *Continue to 2*
❒ Primary central nervous system lymphoma, *Continue to 2*
❒ Meningiomas, *Continue to 2*
❒ Limited and extensive brain metastases, *Continue to 2*
❒ Metastatic spine tumors, *Continue to 2*
❒ Primary Spinal Cord Tumors, *Continue to 2*
❒ Epithelial ovarian cancer, *Continue to 2*
❒ Fallopian tube cancer, *Continue to 2*
❒ Primary peritoneal cancer, *Continue to 2*
❒ Malignant sex cord stromal tumors, *Continue to 2*
❒ Uterine neoplasms, *Continue to 2*
❒ Endometrial carcinoma, *Continue to 2*
❒ Cervical cancer, *Continue to 2*
❒ Vaginal cancer, *Continue to 2*
❒ Renal cell carcinoma, *Continue to 2*
❒ Angiosarcoma, *Continue to 2*
❒ Solitary fibrous tumor or hemangiopericytoma, *Continue to 2*
❒ Mesothelioma (pleural, peritoneal, pericardial, or tunica vaginalis testis), *Continue to 2*
❒ Vulvar carcinoma, including squamous cell carcinoma and adenocarcinoma, *Continue to 2*
❒ Hepatocellular carcinoma, *Continue to 2*
❒ Small bowel adenocarcinoma, *Continue to 2*
❒ Ampullary Adenocarcinoma, *Continue to 2*
❒ Other, please specify. _____, *No further questions*

2. Is this request for continuation of therapy with the requested medication?
❒ Yes, *Continue to 3*
❒ No, *Continue to 4*

3. Has the patient experienced an unacceptable toxicity or disease progression while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

4. What is the diagnosis?
❒ Colon cancer, *No further questions*
❒ Rectal cancer, *No further questions*
❒ Appendiceal adenocarcinoma, *No further questions*
❒ Anal adenocarcinoma, *No further questions*
❒ Non-squamous non-small cell lung cancer (NSCLC), *Continue to 5*
❒ Circumscribed glioma, *No further questions*
❒ Diffuse high grade and high grade gliomas, *No further questions*
❒ Glioblastoma, *No further questions*
❒ IDH mutant astrocytoma (WHO Grade 2, 3 or 4), *No further questions*
❒ Oligodendroglioma (WHO Grade 2 or 3), *No further questions*
❒ Intracranial and spinal ependymoma (excludes subependymoma), *No further questions*
❒ Medulloblastoma, *No further questions*
❒ Primary central nervous system lymphoma, *No further questions*
❒ Meningiomas, *No further questions*
❒ Limited and extensive brain metastases, *No further questions*
❒ Metastatic spine tumors, *No further questions*
❒ Primary Spinal Cord Tumors, *No further questions*
❒ Epithelial ovarian cancer, *No further questions*
❒ Fallopian tube cancer, *No further questions*
❒ Primary peritoneal cancer, *No further questions*
❒ Malignant sex cord stromal tumors, *No further questions*
❒ Uterine neoplasms, *Continue to 6*
❒ Endometrial carcinoma, *Continue to 6*
❒ Cervical cancer, *Continue to 7*
❒ Vaginal cancer, *Continue to 8*
❒ Renal cell carcinoma, *Continue to 9*
❒ Angiosarcoma, *Continue to 10*
❒ Solitary fibrous tumor or hemangiopericytoma, *Continue to 11*
❒ Mesothelioma (pleural, peritoneal, pericardial, or tunica vaginalis testis), *Continue to 12*
❒ Vulvar carcinoma, including squamous cell carcinoma and adenocarcinoma, *Continue to 18*
❒ Hepatocellular carcinoma, *Continue to 19*
❒ Small bowel adenocarcinoma, *No further questions*
❒ Ampullary Adenocarcinoma, *Continue to 24*

5. What is the clinical setting in which the requested medication will be used?
❒ Recurrent disease, *No further questions*
❒ Advanced disease, *No further questions*
❒ Metastatic disease, *No further questions*
❒ Unresectable disease, *No further questions*
❒ Other, please specify. _____, *No further questions*

6. What is the clinical setting in which the requested medication will be used?
❒ Progressive disease, *No further questions*
❒ Persistent disease, *No further questions*
❒ Recurrent disease, *No further questions*
❒ Metastatic disease, *No further questions*
❒ Other, please specify. _____, *No further questions*

7. What is the clinical setting in which the requested medication will be used?
❒ Persistent disease, *No further questions*
❒ Recurrent disease, *No further questions*
❒ Metastatic disease, *No further questions*
❒ Other, please specify. _____, *No further questions*

8. What is the clinical setting in which the requested medication will be used?
❒ Recurrent disease, *No further questions*
❒ Metastatic disease, *No further questions*
❒ Other, please specify. _____, *No further questions*

9. What is the clinical setting in which the requested medication will be used?
❒ Relapsed disease, *No further questions*
❒ Stage IV disease, *No further questions*
❒ Other, please specify. _____, *No further questions*

10. Will the requested medication be given as a single agent therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

11. Will the requested medication be given in combination with temozolomide?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

12. What is the place in therapy in which the requested drug will be used?
❒ First-line treatment, *Continue to 13*
❒ Subsequent treatment, *Continue to 14*

13. 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, *Continue to 16*
❒ No, *Continue to 16*

14. Will the requested drug be used in any of the following regimens?
❒ In combination with pemetrexed (Alimta) and either cisplatin (Platinol) or carboplatin (Paraplatin), *Continue to 15*
❒ In combination with atezolizumab (Tecentriq), *Continue to 17*
❒ No, *No further questions*

15. Has the patient received immunotherapy as first-line treatment?
❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

16. Please indicate the type of mesothelioma which applies to the patient's disease.
❒ Pleural mesothelioma, *No further questions*
❒ Peritoneal mesothelioma, *No further questions*
❒ Pericardial mesothelioma, *No further questions*
❒ Tunica vaginalis testis mesothelioma, *No further questions*
❒ Other, please specify. _____, *No further questions*

17. Please indicate the type of mesothelioma which applies to the patient's disease.
❒ Peritoneal mesothelioma, *No further questions*
❒ Pericardial mesothelioma, *No further questions*
❒ Tunica vaginalis testis mesothelioma, *No further questions*
❒ Other, please specify. _____, *No further questions*

18. What is the clinical setting in which the requested medication will be used?
❒ Advanced disease, *No further questions*
❒ Recurrent disease, *No further questions*
❒ Metastatic disease, *No further questions*
❒ Other, please specify. _____, *No further questions*

19. What is the clinical setting in which the requested medication will be used?
❒ Unresectable disease, *Continue to 20*
❒ Extrahepatic/metastatic disease, *Continue to 20*
❒ Adjuvant treatment, *Continue to 21*
❒ Other, please specify. _____, *No further questions*

20. Will the requested drug be used as initial treatment?
❒ Yes, *Continue to 23*
❒ No, *Continue to 23*

21. What is the clinical setting in which the requested medication will be used?
❒ Operable disease, *Continue to 22*
❒ Other, please specify. _____, *Continue to 22*

22. Is the patient at a high risk of recurrence?
❒ Yes, *Continue to 23*
❒ No, *Continue to 23*

23. Will the requested medication be given in combination with atezolizumab (Tecentriq)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

24. Please indicate the type of ampullary adenocarcinoma which applies to the patient's disease.
❒ Intestinal-type, *Continue to 25*
❒ Other, please specify. _____, *Continue to 25*

25. What is the clinical setting in which the requested medication will be used?
❒ Progressive disease, *No further questions*
❒ Unresectable disease, *No further questions*
❒ Metastatic disease, *No further questions*
❒ Other, please specify. _____, *No further questions*

26. Is this a request for continuation of therapy with the requested medication?
❒ Yes, *Continue to 27*
❒ No, *No Further Questions*

27. 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)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Step Therapy Override: Complete if Applicable for the state of Maryland.	Please Circle	
Is the requested drug being used to treat stage four advanced metastatic cancer?	Yes	No
Is the requested drug's use consistent with the FDA-approved indication or the National Comprehensive Cancer Network Drugs & Biologics Compendium indication for the treatment of stage four advanced metastatic cancer and is supported by peer-reviewed medical literature?	Yes	No
Is the requested drug being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?	Yes	No
Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?	Yes	No
Do patient chart notes document the requested drug was ordered with a paid claim at the pharmacy, the pharmacy filled the prescription and delivered to the patient or other documentation that the requested drug was prescribed for the patient in the last 180 days?	Yes	No
Has the prescriber provided proof documented in the patient chart notes that in their opinion the requested drug is effective for the patient's condition?	Yes	No

Step Therapy Override: Complete if Applicable for the state of Virginia.	Please Circle	
Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)?	Yes	No
Does the prescribed dose and quantity fall within the FDA-approved labeling or within dosing guidelines found in the compendia of current literature?	Yes	No
Is the request for a brand drug that has an AB-rated generic equivalent or interchangeable biological product available?	Yes	No
Has the patient had a trial and failure of the AB-rated generic equivalent or interchangeable biological product due to an adverse event (examples: rash, nausea, vomiting, anaphylaxis) that is thought to be due to an inactive ingredient?	Yes	No
Is the preferred drug contraindicated?	Yes	No
Is the preferred drug expected to be ineffective based on the known clinical characteristics of the patient and the prescription drug regimen?	Yes	No
Has the patient tried the preferred drug while on their current or previous health benefit plan and it was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?	Yes	No
Is the patient currently receiving a positive therapeutic outcome with the requested drug for their medical condition?	Yes	No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720