

BEVACIZUMAB PRIOR APPROVAL REQUEST

Send completed form to: Service Benefit Plan Prior Approval P.O. Box 52080 MC 139 Phoenix, AZ 85072-2080 Attn. Clinical Services Fax: 1-877-378-4727

Federal Employee Program。 **PRIOR APPROVAL REQUEST**Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

P	atient Inform	ation (required)			Provider In	formation ((required)
Date:				Provider Nam	e:		
Patient Name:				Specialty:		NPI:	
Date of Birth:		Sex: □Male	□Female	Office Phone:		Office Fax:	
Street Address:		l		Office Street	Address:	1	
City:		State:	Zip:	City:	5	State:	Zip:
Patient ID: R	1 1]	Physician Sign	nature:		
PHYSICIAN COMPLETES							
	NOTE: Form must be completed in its entirety for processing						
Dlagge galact me	diaatiam.	11012.10mm	ust be comple	ica iii its citalice	y for processing		
Please select me	uication: vacizumab-maly))	ıstin (bevacizı	ımah)	☐Mveci	(bevacizuma	h owwh)
	•		abev (bevacizi	•	□WIVasi	(Devacizuilla	io-awwo)
	evacizumab-adco ue.org/formulary to	,	`	,			
_			=	=			
-	it been on this med		•				swer below:
\Box YES – this	is a PA renewal f	or CONTINUAT	ION of therap	y, please answer	the questions on	PAGE 3	
□ NO - this is	S INITIATION O	f therapy, please a	answer the que	stions below:			
2. Is this request	for brand or gene	ric? □Brand □	Generic				
3. Requests for	Alvmsvs (bevaci	zumab-maly). Ay	vastin (bevaci:	zumab), or Veg	zelma (bevacizui	nab-adcd): E	Does the patient have
3. Requests for Alymsys (bevacizumab-maly), Avastin (bevacizumab), or Vegzelma (bevacizumab-adcd): Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to ONE of the following medications: Zirabev or Mvasi? Yes No						-	
4. What is the pa	atient's diagnosis?	•					
□Glioblaston	□Glioblastoma multiforme (GBM)						
a. Will th	is medication be u	used as a single-ag	gent therapy?	□Yes □No			
b. Has there been progression of the disease following prior therapy? □Yes □No							
□Metastatic cervical cancer <u>OR</u> □Persistent cervical cancer <u>OR</u> □Recurrent cervical cancer							
a. Will the patient be treated with paclitaxel (Taxol)? \(\sigma\)Yes \(\sigma\)No							
b. Will the patient be treated with cisplatin? \(\textstyle \textstyle \texts							
*If NO , will the patient be treated with topotecan (Hycamtin)? \square Yes \square No							
☐ Metastatic colorectal cancer							
a. Is this medication being used as first-line treatment or second-line treatment? □Yes* (*If YES, select answer below) □No							
□ First-line treatment : Is the patient receiving concurrent IV chemotherapy with 5-Fluorouracil (5-FU)? □ Yes □ No							
□Second-line treatment: Will the patient be receiving concurrent therapy with fluoropyrimidine-irinotecan chemotherapy, fluoropyrimidine-oxaliplatin chemotherapy, or 5-fluorouracil-based chemotherapy? □Yes* □No							
*If YES, select answer: \(\sigma 5\)-Fluorouracil-based chemotherapy \(\sigma \) Fluoropyrimidine-irinotecan chemotherapy							
☐Fluoropyrimidine-oxaliplatin chemotherapy							
☐ Metastatic hepatocellular carcinoma (HCC) OR ☐ Unresectable hepatocellular carcinoma (HCC)							
a. Has the patient received prior systemic therapy? \square Yes \square No							
b. Will this medication be given in combination with atezolizumab (Tecentriq)? \(\square\) Yes \(\square\) No							
□ Metastatic renal cell carcinoma							
a. Will the patient be receiving concurrent therapy with interferor				erferon-alfa?	Yes □No		
3, ,, 111 (1)	a. with the patient de receiving concurrent therapy with interferon-ana?						

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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BlueShield. BEVACIZUMAB
Federal Employee Program. PRIOR APPROVAL REQUEST

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PAGE 2 - PHYSICIAN COMPLETES				
Patient Name:	DOB:	Patient ID: R		
□Non-squamous non-small cell lung car				
a. Is this medication being used as f	irst-line therapy? □Yes	\square No		
b. Is the cancer unresectable, locally	advanced, recurrent, or	metastatic? □Yes □No		
c. Will the patient be receiving cond	current therapy with carbo	oplatin and paclitaxel? □Yes □No		
□Ocular disease resulting from intravitr	eal neovascularization in	cluding:		
a. Please select one of the following □Angioid streaks □Oc	; below: cular histoplasmosis	☐Macular edema secondary to retinal vascular occlusion		
☐Diabetic macular edema ☐Pro	ogressive high myopia etinopathy of prematurity	□ Neovascular (Wet) Age-related Macular Degeneration (AMD) □ Proliferative diabetic retinopathy		
indications? □Yes* □No * <i>If YES</i> , please specify the med	dication:	ascular Endothelial Growth Factor (VEGF) inhibitors for ocula ea HD (aflibercept), Lucentis (ranibizumab), Susvimo (ranibizumab)		
Vabysmo (faricimab-svoa)	ireigimue ueil), Lyteu/Lyte	, a 122 (a) 100 (1 a 100 (1 a 110 (1 a		
□Epithelial ovarian cancer <u>OR</u> □F	allopian tube cancer <u>C</u>	<u>DR</u> □ Primary peritoneal cancer		
a. Is the patient undergoing the initi	al surgical resection?	Yes* (*If YES, answer the following questions)		
i. Is the cancer a stage III or sta	age IV disease? □Yes	□No		
ii. Will this medication be given followed by this medication		rboplatin (Paraplatin) and paclitaxel (Taxol) for up to 6 cycles \square No		
b. Is the cancer recurrent platinum-	resistant or recurrent plat	tinum-sensitive? □Yes* □Cancer is not recurrent		
*If YES, please select one of the	following:			
		ation be given concurrently with paclitaxel (Taxol/Onxal), or topotecan (Hycamtin)? □Yes* □No		
*If YES, please select	one of the following belo	ow:		
□paclitaxel (Taxol/Onx	(al) • pegylated liposom	mal doxorubicin (Doxil/Caelyx) □topotecan (Hycamtin)		
		ation be given in combination with carboplatin (Paraplatin) and a single agent? \Box Yes \Box No*		
	cation be given in combination as a single agent?	nation with carboplatin (Paraplatin) and gemcitabine (Gemzar ☐Yes ☐No		
c. Is the patient's cancer considered	l to be advanced? □Yes	* (*If YES, answer the following questions) \text{\$\sigma}\text{No}		
i. Will this medication be given	n in combination with ola	aparib (Lynparza)? □Yes □No		
ii. Has the patient had a comple	ete or partial response to	platinum-based chemotherapy? □Yes* □No		
*If YES, please select one o	f the following below:			
☐Complete response	to platinum-based chemo	otherapy Partial response to platinum-based chemotherap		
d. Is the cancer associated with hor	nologous recombination	deficiency (HRD) positive status? □Yes* □No		
		ositive status defined by deleterious or suspected deleterious BRC *If YES, select one of the following below) □No		
☐Deleterious or suspe	ected deleterious BRCA n	mutation <u>OR</u> Genomic instability		
□Other (nlease specify):				

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Patient Information (required)			Prov	Provider Information (required)			
Date:				Provider Name:			
Patient Name:		Specialty:		NPI:			
Date of Birth:	Date of Birth: Sex: □Male □Female		Office Phone:		Office Fax:		
Street Address:			Office Street Address:				
City:		State:	Zip:	City:	State: Zip:		Zip:
Patient ID: R	, ,			Physician Signature:			
N		I	PHYSICIAN	COMPLETES			
	CON	JTINITA TI	ON OF TI	HERAPY (PA RI	FNFW	\T)	
	COI			•		1L)	
DI .	T1 41	NUIE: Form n	nust de comple	ted in its entirety for pro	ocessing		
	Please select medication: Alymsys (bevacizumab-maly) Avastin (bevacizumab) Mvasi (bevacizumab-awwb)						
	vacizumab-maly) ovocizumab odoc		astin (bevaciz abev (bevaciz	ŕ	⊔ivivasi (I	oevacızumal	o-awwo)
	evacizumab-adco		`				
1. Has the patier ■ NO - this is	nt been on this med s INITIATION o	dication continuo f therapy, please	ously for the las	est 6 months excluding satestions on PAGE 1 by, please answer the que	-		wer below:
2. Is this request	for brand or gene	ric? □Brand □	□Generic				
□Glioblaston	ntient's diagnosis? na multiforme (Gl nis medication be u	BM)	gent therapy?	□Yes □No			
a. Will the b. Will the	cervical cancer $\underline{\mathbf{C}}$ patient be treated patient be treated \mathbf{C} , will the patient	l with paclitaxel (I with cisplatin?	Taxol)?	*	vical cancer		
☐Metastatic o	colorectal cancer						
	_			econd-line treatment? under the condition of the conditi	· -		
fluor		iplatin chemother ver: □5-Fluorour	rapy, or 5-fluor acil-based che	concurrent therapy with couracil-based chemother motherapy Fluorop atin chemotherapy	rapy? ☐Y€		
	_			ctable hepatocellular care lizumab (Tecentriq)? 🗖			
a. Will th	-	ving concurrent th	herapy with int	erferon-alfa? □Yes □	⊒No		
•	nous non-small cel ne patient be receiv	•	herapy with car	rboplatin and paclitaxel?	□Yes	□No	

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PAGE 2 - PHYSICIAN COMPLETES					
Patient Name:	DOB:	Patient ID: R			
Ocular disease resulting from in		ncluding:			
a. Please select one of the fol		Manulan dana arang dana ta matinal arang lang arahasi ar			
□Angioid streaks		☐ Macular edema secondary to retinal vascular occlusion			
	□ Progressive high myopia □ Retinopathy of prematurity	□ Neovascular (Wet) Age-related Macular Degeneration (AMD) □ Proliferative diabetic retinopathy			
b. Will this medication be used in combination with other Vascular Endothelial Growth Factor (VEGF) inhibitors for ocular indications? *If YES, please specify the medication: *VEGF Inhibitors: Beovu (brolucizumab-dbll), Eylea/Eylea HD (aflibercept), Lucentis (ranibizumab), Susvimo (ranibizumab), Vabysmo (faricimab-svoa)					
□Epithelial ovarian cancer OR	☐Fallopian tube cancer	OR Primary peritoneal cancer			
a. Will this medication be use	ed as single agent therapy post	initial surgical resection? □Yes □No			
b. Is the cancer recurrent plat *If YES, please select o		inum sensitive? □Yes* □Cancer is not recurrent			
pegylated liposom * <i>If YES</i> , please	nal doxorubicin (Doxil/Caelyx) select one of the following bel	ation be given concurrently with paclitaxel (Taxol/Onxal), , or topotecan (Hycamtin)? □Yes* □No ow: somal doxorubicin (Doxil/Caelyx) □topotecan (Hycamtin)			
□Recurrent Platin	um Sensitive: Will this medica	ation be used as single agent therapy? \(\sigma\)Yes \(\sigma\)No			
c. Is the patient's cancer con	sidered to be advanced? \(\begin{align*} \Pi \text{Yes} \\ \\ \end{align*}				
□Other (please specify):					

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