BlueCross BlueShield Federal Employee Program

BEVACIZUMAB
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.

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

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

NOTE: Form must be completed in its **entirety** for processing

Please select medication:

❑**Alymsys (bevacizumab-maly)** ❑**Avastin (bevacizumab)** ❑**Mvasi (bevacizumab-awwb)**

❑**Vegzelma (bevacizumab-adcd)** ❑**Zirabev (bevacizumab-bvzr)**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

1. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 3**
   ❑**NO** - this is **INITIATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
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 patient's diagnosis?
   ❑Glioblastoma multiforme (GBM)
      a. Will this medication be used as a single-agent therapy? ❑Yes ❑No
      b. Has there been progression of the disease following prior therapy? ❑Yes ❑No
   ❑Metastatic cervical cancer **OR** ❑Persistent cervical cancer **OR** ❑Recurrent cervical cancer
      a. Will the patient be treated with paclitaxel (Taxol)? ❑Yes ❑No
      b. Will the patient be treated with cisplatin? ❑Yes ❑No*
         If NO, will the patient be treated with topotecan (Hycamtin)? ❑Yes ❑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: ❑5-Fluorouracil-based chemotherapy ❑Fluoropyrimidine-irinotecan chemotherapy
            ❑Fluoropyrimidine-oxaliplatin chemotherapy
   ❑Metastatic hepatocellular carcinoma (HCC) **OR** ❑Unresectable hepatocellular carcinoma (HCC)
      a. Has the patient received prior systemic therapy? ❑Yes ❑No
      b. Will this medication be given in combination with atezolizumab (Tecentriq)? ❑Yes ❑No
   ❑Metastatic renal cell carcinoma
      a. Will the patient be receiving concurrent therapy with interferon-alfa? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ **DOB:** _____ **Patient ID: R** _____

❑Non-squamous non-small cell lung cancer

a. Is this medication being used as first-line therapy? ❑Yes ❑No

b. Is the cancer unresectable, locally advanced, recurrent, or metastatic? ❑Yes ❑No

c. Will the patient be receiving concurrent therapy with carboplatin and paclitaxel? ❑Yes ❑No

❑Ocular disease resulting from intravitreal neovascularization including:

a. Please select one of the following below:

❑Angioid streaks ❑Ocular histoplasmosis ❑Macular edema secondary to retinal vascular occlusion
❑Diabetic macular edema ❑Progressive high myopia ❑Neovascular (Wet) Age-related Macular Degeneration (AMD)
❑Neovascular glaucoma ❑Retinopathy of prematurity ❑Proliferative diabetic retinopathy

b. Will this medication be used in combination with other Vascular Endothelial Growth Factor (VEGF) inhibitors for ocular indications? ❑Yes* ❑No

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. Is the patient undergoing the initial surgical resection? ❑Yes* ***(*If YES, answer the following questions)*** ❑No

i. Is the cancer a stage III or stage IV disease? ❑Yes ❑No

ii. Will this medication be given in combination with carboplatin (Paraplatin) and paclitaxel (Taxol) for up to 6 cycles followed by this medication as a single agent? ❑Yes ❑No

b. Is the cancer recurrent platinum-resistant or recurrent platinum-sensitive? ❑Yes* ❑Cancer is not recurrent

If YES, please select one of the following:

❑**Recurrent Platinum-Resistant:** Will this medication be given concurrently with paclitaxel (Taxol/Onxal), pegylated liposomal doxorubicin (Doxil/Caelyx), or topotecan (Hycamtin)? ❑Yes* ❑No

If YES, please select one of the following below:

❑paclitaxel (Taxol/Onxal) ❑pegylated liposomal doxorubicin (Doxil/Caelyx) ❑topotecan (Hycamtin)

❑**Recurrent Platinum-Sensitive**: Will this medication be given in combination with carboplatin (Paraplatin) and paclitaxel (Taxol) followed by this medication as a single agent? ❑Yes ❑No*

If NO, will this medication be given in combination with carboplatin (Paraplatin) and gemcitabine (Gemzar) followed by this medication as a single agent? ❑Yes ❑No

c. Is the patient's cancer considered to be advanced? ❑Yes* ***(*If YES, answer the following questions)*** ❑No

i. Will this medication be given in combination with olaparib (Lynparza)? ❑Yes ❑No

ii. Has the patient had a complete or partial response to platinum-based chemotherapy? ❑Yes* ❑No

If YES, please select one of the following below:

❑Complete response to platinum-based chemotherapy ❑Partial response to platinum-based chemotherapy

d. Is the cancer associated with homologous recombination deficiency (HRD) positive status? ❑Yes* ❑No

If YES, is the homologous recombination deficiency positive status defined by deleterious or suspected deleterious BRCA mutation or defined by genomic instability? ❑Yes* ***(*If YES, select one of the following below)*** ❑No

❑Deleterious or suspected deleterious BRCA mutation **OR** ❑Genomic instability

❑Other ***(please specify)***: _____

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Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

CONTINUATION OF THERAPY (PA RENEWAL)

NOTE: Form must be completed in its **entirety** for processing

Please select medication:

❑**Alymsys (bevacizumab-maly)** ❑**Avastin (bevacizumab)** ❑**Mvasi (bevacizumab-awwb)**
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1. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
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      a. Will this medication be used as a single-agent therapy? ❑Yes ❑No

   ❑Metastatic cervical cancer **OR** ❑Persistent cervical cancer **OR** ❑Recurrent cervical cancer
      a. Will the patient be treated with paclitaxel (Taxol)? ❑Yes ❑No
      b. Will the patient be treated with cisplatin? ❑Yes ❑No*****
         ****If NO***, will the patient be treated with topotecan (Hycamtin)? ❑Yes ❑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: ❑5-Fluorouracil-based chemotherapy ❑Fluoropyrimidine-irinotecan chemotherapy
            ❑Fluoropyrimidine-oxaliplatin chemotherapy

   ❑Metastatic hepatocellular carcinoma (HCC) **OR** ❑Unresectable hepatocellular carcinoma (HCC)
      a. Will this medication be given in combination with atezolizumab (Tecentriq)? ❑Yes ❑No

   ❑Metastatic renal cell carcinoma
      a. Will the patient be receiving concurrent therapy with interferon-alfa? ❑Yes ❑No

   ❑Non-squamous non-small cell lung cancer
      a. Will the patient be receiving concurrent therapy with carboplatin and paclitaxel? ❑Yes ❑No

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❑Diabetic macular edema ❑Progressive high myopia ❑Neovascular (Wet) Age-related Macular Degeneration (AMD)
❑Neovascular glaucoma ❑Retinopathy of prematurity ❑Proliferative diabetic retinopathy

b. Will this medication be used in combination with other Vascular Endothelial Growth Factor (VEGF) inhibitors for ocular indications? ❑Yes* ❑No

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 used as single agent therapy post initial surgical resection? ❑Yes ❑No

b. Is the cancer recurrent platinum resistant or recurrent platinum sensitive? ❑Yes* ❑Cancer is not recurrent

If YES, please select one of the following:

❑**Recurrent Platinum Resistant**: Will this medication be given concurrently with paclitaxel (Taxol/Onxal), pegylated liposomal doxorubicin (Doxil/Caelyx), or topotecan (Hycamtin)? ❑Yes* ❑No

If YES, please select one of the following below:

❑paclitaxel (Taxol/Onxal) ❑pegylated liposomal doxorubicin (Doxil/Caelyx) ❑topotecan (Hycamtin)

❑**Recurrent Platinum Sensitive**: Will this medication be used as single agent therapy? ❑Yes ❑No

c. Is the patient's cancer considered to be advanced? ❑Yes* ❑No

If YES, will this medication be given in combination with olaparib (Lynparza)? ❑Yes ❑No

❑Other ***(please specify)***: _____