

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	formatio <u>n</u>	(required)
Date:				Provider Nam	ne:		
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:		State:	Zip:
Patient ID: R	1 1]	Physician Sig	nature:		
PHYSICIAN COMPLETES							
NOTE: Form must be completed in its entirety for processing							
Dlagge galact ma	diaatian.	11012: 1 om m	ust be comple	ica ili its citii ci	y for processing		
Please select me	vacizumab-maly))	ıstin (bevacizı	ımah)	□Mvoci	(bevacizuma	ah awwh)
	•		abev (bevacizi	•	umvasi	(Devacizuma	iD-awwD)
	evacizumab-adco	confirm which medic	`				
_			=	-			
•		dication continuor	•		• •		swer below:
\Box YES – this	is a PA renewal f	for CONTINUAT	ION of therap	y, please answer	r 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	eric? □Brand □	Generic				
3. Requests for	Alvmsvs (bevaci	zumab-maly). Ay	vastin (bevaci:	zumab), or Veg	zelma (bevacizui	nab-adcd): [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	tient's diagnosis?	•					
□Glioblaston	na multiforme (Gl	BM)					
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							
\square Metastatic cervical cancer \underline{OR} \square Persistent cervical cancer \underline{OR} \square Recurrent cervical cancer							
a. Will the patient be treated with paclitaxel (Taxol)? \(\sigma\)Yes \(\sigma\)No							
b. Will the patient be treated with cisplatin? \(\sigma\)Yes \(\sigma\)No*							
*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? \(\sigma\)Yes* \(\sigma\)No **If YES, select answer: \(\sigma5\)-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)? Yes No							
☐ Metastatic renal cell carcinoma							
				erferon-alfa? 🗖	Yes □No		
a. Will the patient be receiving concurrent therapy with interferon-alfa? □Yes □No							

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

PAGE 1 of 4



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	□No		
b. Is the cancer unresectable, locally	advanced, recurrent, or	metastatic? \(\subseteq Yes \) \(\subseteq No \)		
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	n	
☐Diabetic macular edema ☐Pro	ogressive high myopia etinopathy of prematurity	□ Neovascular (Wet) Age-related Macular Degeneration □ Proliferative diabetic retinopathy		
indications? □Yes* □No * <i>If YES</i> , please specify the med	lication:	ascular Endothelial Growth Factor (VEGF) inhibitors ea HD (aflibercept), Lucentis (ranibizumab), Susvimo (ra		
Vabysmo (faricimab-svoa)	ucizumuo-uoii), Eyieu/Eyie	eu IID (ajuvercept), Lucenus (rumvizumuv), Susvimo (ru	шощинио) ₃	
□Epithelial ovarian cancer <u>OR</u> □F	Fallopian tube cancer C	DR □ Primary peritoneal cancer		
a. Is the patient undergoing the initi	al surgical resection?	Yes* (*If YES, answer the following questions)	0	
i. Is the cancer a stage III or sta	=	□No		
ii. Will this medication be given followed by this medication		rboplatin (Paraplatin) and paclitaxel (Taxol) for up to s □No	o 6 cycles	
b. Is the cancer recurrent platinum-	resistant or recurrent plat	tinum-sensitive?	ent	
*If YES, please select one of the	following:			
		ation be given concurrently with paclitaxel (Taxol/On, or topotecan (Hycamtin)? \(\bar{\text{Y}} \) Yes* \(\bar{\text{U}} \) No	nxal),	
*If YES, please select	one of the following belo	ow:		
□paclitaxel (Taxol/Onx	(al) pegylated liposon	mal doxorubicin (Doxil/Caelyx) ☐ topotecan (Hycamt	tin)	
		ation be given in combination with carboplatin (Paraps a single agent? Yes No*	platin) and	
	cation be given in combination as a single agent?	ination with carboplatin (Paraplatin) and gemcitabine \(\subseteq \text{Yes} \) \(\subseteq \text{No} \)	(Gemzar)	
c. Is the patient's cancer considered	d to be advanced? □Yes	* (*If YES, answer the following questions)		
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	notherapy Partial response to platinum-based che	motherapy	
d. Is the cancer associated with hor	nologous recombination	deficiency (HRD) positive status? □Yes* □No		
		positive status defined by deleterious or suspected delete *If YES, select one of the following below)	rious BRC	
☐Deleterious or suspe	cted deleterious BRCA n	mutation <u>OR</u> Genomic instability		
□Other (nlease specify):				

PAGE 2 of 4



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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:	St	ate:	Zip:
Patient ID: R	, ,			Physician Signature:			
N		I	PHYSICIAN	COMPLETES			
	CON	JTINITATI	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)? \(\textsquare \text{Yes} \)	*	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	

PLEASE PROCEED TO PAGE 4 FOR ADDITIONAL DIAGNOSES

PAGE 3 of 4



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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):					

PAGE 4 of 4