MEDICARE FORM

AVASTIN™ (bevacizumab)
ALYMSYS™ (bevacizumab-maly)
AVZIVI™ (bevacizumab-tnjn)
MVASI™ (bevacizumab-awwb)
VEGZELMA® (bevacizumab-adcd)
ZIRABEV™ (bevacizumab-bvzr)
Medication Precertification Request

(All fields must be completed and legible for precertification review.)

For Medicare Advantage Part B:
For other lines of business:
Please use commercial form.

Note: Alymsys, Avastin, Avzivi and Vegzelma are non-preferred. The preferred biosimilar products are Mvasi and Zirabev. Bevacizumab (Avastin) does not require precertification for ophthalmic use.

Would you like to use electronic prior authorization? Consider using **Availity**, our electronic prior authorization portal. Learn more about **Availity** from the links in the table below.

For phone or fax requests, refer to the table below for routing information. To determine which box to use, refer to the patient's Aetna ID card. State specific special needs and Medicare-Medicaid Plans may be designated on the front of the ID card or in the website URL on the back of the card. If you don't see your specific plan listed, call the number on the back of the member's ID card to confirm routing information.

For **Aetna Medicare Advantage** and **Allina Health Aetna Medicare** members send request to: **Phone:** 1-866-503-0857 **(TTY:** 711**)** **Fax:** 1-844-268-7263 **Availity:** https://www.aetna.com/health-care-professionals/resource-center/availity.html
For Aetna Medicare Advantage **Virginia Dual Eligible Special Needs Plans** (HMO D-SNP) send request to: **Phone:** 1-855-463-0933 **Fax:** 1-833-280-5224 **Availity:** https://www.aetnabetterhealth.com/virginia-hmosnp/providers/portal
For Aetna Assure Premier Plus Medicare Advantage **New Jersey Dual Eligible Special Needs Plans** (HMO D-SNP) send request to: **Phone:** 1-844-362-0934 **Fax:** 1-833-322-0034 **Availity:** https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/portal.html
For Aetna Better Health of **Illinois Premier Medicare Medicaid Plan** (MMP) send request to: **Phone:** 1-866-600-2139 **FAX:** 1-855-320-8445 **Availity:** https://www.aetnabetterhealth.com/illinois/providers/portal
For Aetna Better Health of **Ohio Premier Medicare Medicaid Plan** (MMP) send request to: **Phone:** 1-855-364-0974 **Fax:** 1-855-734-9389 **Availity:** https://www.aetnabetterhealth.com/ohio/providers/portal
For Aetna Better Health of **Michigan Premier Medicare Medicaid Plan** (MMP) send request to: **Phone:** 1-855-676-5772 **Fax:** 1-844-241-2495 **Availity:** https://www.aetnabetterhealth.com/michigan/providers/portal.html

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Please indicate: ☐ Start of treatment: Start date ____/____/____ ☐ Continuation of therapy, Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		DOB:	
Address:		City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:	
Patient Current Weight: ____ lbs or ____ kgs Patient Height: ____ inches or ____ cms			Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:			City:	State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Oncologist** ☐ **Ophthalmologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

E. PRODUCT INFORMATION

Request is for: ☐ **AVASTIN (bevacizumab)** ☐ **ALYMSYS™ (bevacizumab-maly)** ☐ **AVZIVI™ (bevacizumab-tnjn)**
☐ **MVASI (bevacizumab-awwb)** ☐ **VEGZELMA (bevacizumab-adcd)** ☐ **ZIRABEV (bevacizumab-bvzr)**

Dose: _____ **Frequency:** _____ **HCPCS Code:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: _____ **Secondary ICD Code:** _____ **Other ICD Code:** _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For Initiation Requests (clinical documentation required for all requests):

Ophthalmic disorders (Precertification is not required for compounded Avastin (bevacizumab) for ophthalmic use):

☐ Yes ☐ No Is this request for Avastin treatment?
→ ☐ Yes ☐ No Has the patient tried and failed treatment with Avastin due to a documented intolerable adverse event (e.g., rash, nausea, vomiting)?
☐ Yes ☐ No Was the adverse event unexpected and not attributed to the active ingredient as described in the prescribing information?

Please select the diagnosis:

☐ Choroidal neovascularization (CNV) (including myopic choroidal neovascularization (mCNV), angioid streaks, choroiditis [including choroiditis secondary to ocular histoplasmosis], idiopathic degenerative myopia, retinal dystrophies, rubeosis iridis, pseudoxanthoma elasticum, and trauma)
☐ Diabetic macular edema ☐ Macular edema following retinal vein occlusion (RVO) ☐ Neovascular (wet) Age-Related Macular Degeneration (AMD)
☐ Neovascular glaucoma ☐ Polypoidal choroidal vasculopathy ☐ Proliferative diabetic retinopathy ☐ Retinopathy of prematurity

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests

Oncology indications:

Note: Alymsys, Avastin, Avzivi and Vegzelma are non-preferred. The preferred biosimilar products are Mvasi and Zirabev.

☐ Yes ☐ No Has the patient had prior therapy with requested product within the last 365 days?

☐ No Has the patient had a trial and failure of any of the following Avastin biosimilars? (if yes, select all that apply below)

☐ Mvasi (bevacizumab-awwb) ☐ Zirabev (bevacizumab-bvzr)

→ When was the member's trial and failure of the preferred biosimilar? _____

→ Please describe the nature of the failure to the preferred biosimilar _____

☐ No Has the patient had an adverse reaction to any of the following Avastin biosimilars? (if yes, select all that apply below)

☐ Mvasi (bevacizumab-awwb) ☐ Zirabev (bevacizumab-bvzr)

→ When was the member's adverse reaction to the preferred biosimilar? _____

→ Please describe the nature of the adverse reaction to the preferred biosimilar _____

Please explain if there are any contraindications or other medical reason(s) that the patient cannot use any of the following preferred biosimilar products when indicated for the patient's diagnosis? (select all that apply)

☐ Mvasi (bevacizumab-awwb) ☐ Zirabev (bevacizumab-bvzr)

_____

_____

Please select the diagnosis:

☐ Ampullary Adenocarcinoma

→ Please indicate the type of ampullary adenocarcinoma which applies to the patient's disease: ☐ Intestinal-type ☐ Other

☐ Yes ☐ No Does the patient have progressive, unresectable, or metastatic disease?

→ Please select: ☐ progressive disease ☐ unresectable disease ☐ metastatic disease ☐ none of the above

☐ Anaplastic glioma

☐ Angiosarcoma

→ ☐ Yes ☐ No Will the requested medication be given as a single agent therapy?

☐ Breast cancer

→ ☐ Yes ☐ No Does the patient have recurrent or metastatic disease?

→ Please select: ☐ recurrent disease ☐ metastatic disease ☐ none of the above

☐ Cervical cancer

→ ☐ Yes ☐ No Does the patient have persistent, recurrent, or metastatic disease?

→ Please select: ☐ persistent disease ☐ recurrent disease ☐ metastatic disease ☐ none of the above

☐ Colorectal cancer, including appendiceal adenocarcinoma and anal adenocarcinoma

☐ Diffuse high grade gliomas

☐ Glioblastoma

☐ Endometrial carcinoma

→ ☐ Yes ☐ No Does the patient have progressive, advanced, recurrent, or metastatic disease?

→ Please select: ☐ progressive disease ☐ advanced disease ☐ recurrent disease ☐ metastatic disease ☐ none of the above

☐ Epithelial ovarian cancer (including carcinosarcoma [malignant mixed Müllerian tumors], clear cell carcinoma, mucinous carcinoma, endometrioid carcinoma, serous carcinoma, and malignant sex cord-stromal tumors)

☐ Fallopian tube cancer

☐ Gastric cancer

☐ Hepatocellular carcinoma

→ ☐ Yes ☐ No Does the patient have unresectable or metastatic disease?

→ Please select: ☐ unresectable disease ☐ metastatic disease ☐ none of the above

☐ Yes ☐ No Will the requested drug be used as initial treatment?

☐ Yes ☐ No Will the requested medication be given in combination with atezolizumab (Tecentriq)?

☐ IDH mutant astrocytoma (WHO Grade 2, 3, or 4)

☐ Intracranial and spinal ependymoma (excludes subependymoma)

☐ Limited and extensive brain metastases

☐ Low-grade (WHO Grade 1 or 2) Glioma

☐ Medulloblastoma

☐ Meningiomas

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests

☐ Mesothelioma
→ Please indicate the type of mesothelioma which applies to the patient's disease:
☐ malignant pleural mesothelioma ☐ malignant peritoneal mesothelioma ☐ pericardial mesothelioma ☐ tunica vaginalis testis mesothelioma
☐ other
Please indicate the place in therapy in which the requested drug will be used:
☐ First-line treatment
→ ☐ Yes ☐ No 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 ☐ No Does the patient have unresectable disease?
☐ Subsequent treatment
→ Please select the requested regimen:
☐ In combination with pemetrexed (Alimta) and either cisplatin (Platinol) or carboplatin (Paraplatin)
→ ☐ Yes ☐ No Has the patient received immunotherapy as first-line treatment?
☐ In combination with atezolizumab (Tecentriq)
☐ Other

☐ Metastatic spine tumors
☐ Necrosis of central nervous system due to exposure to ionizing radiation
☐ Non-squamous non-small cell lung cancer (NSCLC)
→ ☐ Yes ☐ No Does the patient have recurrent, advanced, metastatic, or unresectable disease?
→ Please select: ☐ recurrent disease ☐ advanced disease ☐ metastatic disease ☐ unresectable disease ☐ none of the above
☐ Oligodendroglioma (WHO Grade 2 or 3)
☐ Primary central nervous system lymphoma
☐ Primary peritoneal cancer
☐ Renal cell carcinoma
→ ☐ Yes ☐ No Does the patient have relapsed or stage IV disease? ☐ relapsed disease ☐ stage IV disease ☐ none of the above
☐ Small bowel adenocarcinoma
☐ Solitary fibrous tumor or hemangiopericytoma
→ ☐ Yes ☐ No Will the requested medication be given in combination with temozolomide (Temodar)?
☐ Uterine neoplasms
→ ☐ Yes ☐ No Does the patient have progressive, advanced, recurrent, or metastatic disease?
→ Please select: ☐ progressive disease ☐ advanced disease ☐ recurrent disease ☐ metastatic disease ☐ none of the above
☐ Vaginal cancer
→ ☐ Yes ☐ No Does the patient have persistent, recurrent, or metastatic disease?
→ Please select: ☐ persistent disease ☐ recurrent disease ☐ metastatic disease ☐ none of the above
☐ Vulvar squamous cell carcinoma
→ ☐ Yes ☐ No Does the patient have unresectable locally advanced, recurrent, or metastatic disease?
→ Please select: ☐ unresectable locally advanced disease ☐ recurrent disease ☐ metastatic disease ☐ none of the above

For Continuation Requests (clinical documentation required for all requests):

Ophthalmic disorders:
☐ Yes ☐ No 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)?

Oncology indications:
☐ Yes ☐ No Has the patient experienced an unacceptable toxicity or disease progression while on the current regimen?

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.