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.)

Aetna Precertification Notification
Phone: 1-866-752-7021 **(TTY:** 711**)**
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

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: _____

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

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:** _____

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:
☐ 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?
☐ Yes ☐ No Has the patient had an ineffective response, contraindication or intolerance to Byooviz OR Cimerli?

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

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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

Oncology indications:

☐ Yes ☐ No Is this request for Mvasi treatment?
→ ☐ Yes ☐ No Has the patient tried and failed treatment with Mvasi 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:

☐ Ampullary Adenocarcinoma
→ Please indicate the type of ampullary adenocarcinoma which applies to the patient's disease: ☐ Intestinal-type ☐ Other
☐ Yes ☐ No What is the clinical setting in which the requested medication will be used?
→ Please select: ☐ Progressive disease ☐ Unresectable disease ☐ Metastatic disease ☐ Other

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

☐ Breast cancer
→ ☐ Yes ☐ No What is the clinical setting in which the requested medication will be used?
→ Please select: ☐ Metastatic disease ☐ Other

☐ Cervical cancer
→ ☐ Yes ☐ No What is the clinical setting in which the requested medication will be used?
→ Please select: ☐ Persistent disease ☐ Recurrent disease ☐ Metastatic disease ☐ Other

☐ Colorectal cancer, including appendiceal adenocarcinoma and anal adenocarcinoma

☐ Diffuse high grade gliomas

☐ Glioblastoma

☐ Circumscribed glioma

☐ Endometrial carcinoma
→ ☐ Yes ☐ No What is the clinical setting in which the requested medication will be used?
→ Please select: ☐ Progressive disease ☐ Recurrent disease ☐ Metastatic disease ☐ Other

☐ Epithelial ovarian cancer

☐ Fallopian tube cancer

☐ Hepatocellular carcinoma
→ ☐ Yes ☐ No What is the clinical setting in which the requested medication will be used?
→ Please select: ☐ Unresectable disease ☐ Inoperable disease ☐ Metastatic disease ☐ Other
☐ 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

☐ Malignant sex cord stromal tumors

☐ Medulloblastoma

☐ Meningiomas

☐ Metastatic spine tumors

☐ Non-squamous non-small cell lung cancer (NSCLC)
→ ☐ Yes ☐ No What is the clinical setting in which the requested medication will be used?
→ Please select: ☐ Recurrent disease ☐ Advanced disease ☐ Metastatic disease ☐ Unresectable disease ☐ Other

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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:
    ☐ Pleural mesothelioma ☐ 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?
    - ☐ 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
- ☐ Oligodendroglioma (WHO Grade 2 or 3)
- ☐ Primary central nervous system lymphoma
- ☐ Primary peritoneal cancer
- ☐ Renal cell carcinoma
  - → What is the clinical setting in which the requested medication will be used? ☐ Relapsed disease ☐ Stage IV disease ☐ Other
- ☐ Small bowel adenocarcinoma
- ☐ Solitary fibrous tumor or hemangiopericytoma
  - → ☐ Yes ☐ No Will the requested medication be given in combination with temozolomide (Temodar)?
- ☐ Vaginal cancer
  - → ☐ Yes ☐ No What is the clinical setting in which the requested medication will be used?
    - → Please select: ☐ Persistent disease ☐ Recurrent disease ☐ Metastatic disease ☐ Other
- ☐ Uterine neoplasms
  - → ☐ Yes ☐ No What is the clinical setting in which the requested medication will be used?
    - → Please select: ☐ Progressive disease ☐ Recurrent disease ☐ Metastatic disease ☐ Other
- ☐ Vulvar carcinoma, including squamous cell carcinoma and adenocarcinoma
  - → ☐ Yes ☐ No What is the clinical setting in which the requested medication will be used?
    - → Please select: ☐ Advanced disease ☐ Recurrent disease ☐ Metastatic disease ☐ Other

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.