Updated: 01/2019
PARP Approved: 01/2019

Prior Authorization Criteria

Avastin® (bevacizumab) and bevacizumab biosimilar

All requests for Avastin® (bevacizumab) and bevacizumab biosimilar require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

For all requests for Avastin® (bevacizumab) and bevacizumab biosimilar all of the following criteria must be met:

- The prescribing physician must be a hematologist/oncologist or retinal specialist
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- For non-formulary agents, the member has had a trial and failure of a formulary agent or a clinically submitted reason for not having a trial of a formulary agent

Coverage may be provided with a diagnosis of Cervical Cancer and the following criteria is met:

- The drug will be used in combination with paclitaxel and cisplatin or paclitaxel and topotecan for persistent, recurrent, or metastatic disease

Coverage may be provided with a diagnosis of Colorectal Cancer and the following criteria is met:

- The disease is metastatic
- The drug will be used in combination with intravenous 5-fluorouracil (IFL)-based chemotherapy for first- or second-line treatment, OR
- The drug will be used in combination with fluoropyrimidine- irinotecan- or fluoropyrimidine-oxaliplatin-based chemotherapy for second-line treatment in members who have progressed on a first-line bevacizumab-containing regimen

Coverage may be provided with a diagnosis of Glioblastoma and the following criteria is met:

- The drug will be used for recurrent disease (prior therapy examples include radiotherapy, temozolomide, lomustine, carmustine, etc.).

Coverage may be provided with a diagnosis of Non-Small Cell Lung Cancer and the following criteria is met:

- The disease is of non-squamous origin
- The drug will be used in combination with carboplatin and paclitaxel for first-line treatment of unresectable, locally advanced, recurrent, or metastatic disease

Coverage may be provided with a diagnosis of Epithelial Ovarian, Fallopian Tube, or Primary Peritoneal Cancer and the following criteria is met (Avastin (bevacizumab) only):

- In combination with paclitaxel, pegylated liposomal doxorubicin, or topotecan in members with platinum-resistant recurrent disease.
- In combination with carboplatin and paclitaxel or in combination with carboplatin and gemcitabine, followed by Avastin as a single agent in members with platinum-sensitive recurrent disease.
- In combination with carboplatin and paclitaxel followed by Avastin as a single agent in members with Stage III or IV disease following initial surgical resection.

Coverage may be provided with a diagnosis of is Renal Cell Carcinoma and the following criteria is met:

- The drug will be used in combination with interferon-alfa

Coverage may be provided with a diagnosis of Choroidal Neovascularization (CNV) associated with age related macular degeneration, angioid streaks, secondary to pathologic myopia, histoplasmosis, or idiopathic CNV

Coverage may be provided with a diagnosis of Diabetic Retinopathy

Coverage may be provided with a diagnosis of Diabetic Macular Edema and the following criteria is met:

- The member has Clinically Significant Macular Edema defined as having one or more of the following:
    - Thickening of the retina at or within 500 μm of the center of the macula
    - Hard exudates at or within 500 μm of the center of the macula, when associated with adjacent retinal thickening. (This criteria does not apply to residual hard exudates that remain after successful treatment of prior retinal thickening.)
    - Retinal thickening one disc area or larger, where any portion of the thickening is within one disc diameter of the center of the macula
    - Confirmation of the diagnosis by an (OCT) Optical Coherence Tomography

Coverage may be provided with a diagnosis of Macular Edema due to Branch Retinal Vein Occlusion, Central Retinal Vein Occlusion (RVO), or other non-diabetic causes

Coverage may be provided with a diagnosis of Neovascular Glaucoma

Coverage may be provided with a diagnosis of Retinopathy of Prematurity

- **Initial Duration of Approval:**
  - Oncology indications: 6 months
  - Retinopathy of Prematurity: 1 month
  - All other ophthalmic indications: 12 months
- **Reauthorization Criteria**
  - Chart documentation demonstrating clinical benefit and tolerance to Avastin or bevacizumab biosimilar
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

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AVASTIN (BEVACIZUMAB) AND BEVACIZUMAB BIOSIMILAR PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Gateway Health[SM] Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Gateway ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis: _____ Diagnosis code: _____
Will the requested medication be used in combination with another medication? ☐ Yes ☐ No
If yes please list the name of the medication: _____

If the member has Macular Edema please select which of the following applies to the member:

☐ The member has thickening of the retina at or within 500 μm of the center of the macula
☐ The member has hard exudates at or within 500 μm of the center of the macula, and has adjacent retinal thickening.
☐ The member has retinal thickening one disc area or larger, where any portion of the thickening is within one disc diameter of the center of the macula
☐ The diagnosis was confirmed by an (OCT) Optical Coherence Tomography

☐ None of the above

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CURRENT or PREVIOUS THERAPY			
Medication Name	**Strength/ Frequency**	**Dates of Therapy**	**Status (Discontinued & Why/Current)**

REAUTHORIZATION
Has the member experienced a significant improvement with treatment? ☐ Yes ☐ No Please describe:

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date