Updated: 8/2019
DMMA Approved: 8/2019

Request for Prior Authorization for Avastin® (bevacizumab) and bevacizumab biosimilar
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

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.

Avastin® (bevacizumab) and bevacizumab biosimilar Prior Authorization Criteria:

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-preferred agents, the member has had a trial and failure of a preferred agent or a clinically submitted reason for not having a trial of a preferred 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 who received no more than 2 prior chemotherapy regimens.
- 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.

HIGHMARK. Delaware HEALTH OPTIONS

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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 Health Options Pharmacy Services. **FAX:** 1-855-476-4158
If needed, you may call to speak to a Pharmacy Services Representative **PHONE**: 1-844-325-6251

PROVIDER INFORMATION

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

MEMBER INFORMATION

Member Name:	
Health Options ID:	DOB:

DRUG INFORMATION

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

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

BILLING INFORMATION

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

Place of service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Infusion Center ☐ Other

PLACE OF SERVICE INFORMATION

Name:	**NPI:**
Address:	**Phone:**

MEDICAL HISTORY

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

REAUTHORIZATION

Is there documentation of clinical benefit and tolerance to therapy? ☐ Yes ☐ No

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Member Name	
Health Options ID	**DOB**

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

ADDITIONAL SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Physician Signature	**Date**