Updated: 05/2022
PARP Approved: 05/2022

Prior Authorization Criteria

Avastin (bevacizumab) and bevacizumab biosimilars

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

For all oncology-related requests for Avastin® (bevacizumab) and bevacizumab biosimilars, please refer to the Oncology Medications, IV/Injectable policy (CP-206.133-MD-PA).

For all ophthalmic-related requests for Avastin® (bevacizumab) and bevacizumab biosimilars, coverage may be provided for a FDA approved, compendia supported, or peer reviewed medical literature supported diagnosis

- **Duration of Approval:**
  - Retinopathy of Prematurity: 1 month
  - All other ophthalmic indications: 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.

HIGHMARK WHOLECARE

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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 Highmark Wholecare Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (800) 392-1147 Mon – Fri 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:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
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: _____

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