



**Outpatient Chemotherapy
 Avastin (Bevacizumab) Request Form
 Fax to 833-581-1861
 (Medical Benefit Only)**

Member Name: _____

Member Date of Birth: _____

Member ID (UMI): _____ Medicare Commercial

ORDERING/ATTENDING PROVIDER

Name: _____ NPI: _____

Address: _____

Office Contact: _____ Phone #: _____ Fax #: _____

SERVICING FACILITY/VENDOR

Name: _____ NPI: _____

Address: _____

Requested Start Date of Service: _____

HCPCS J Code (s): _____ ICD10 Diagnosis Code(s): _____

Please answer the following clinical questions:

DRUG INFORMATION (please select one)	
<u>PREFERRED for ALL indications</u>	<u>NON-PREFERRED**</u>
<input type="checkbox"/> Mvasi (Q5107) <input type="checkbox"/> Zirabev (Q5118)	<input type="checkbox"/> Avastin (J9035) <input type="checkbox"/> Alymsys (Q5126) <input type="checkbox"/> Vegzelma (Q5129) <p><small>**A non-preferred product will be considered when the member has documented therapy failure after an adequate therapeutic trial of a preferred product, or the preferred product has not been tolerated or is contraindicated</small></p> <p><small>**<u>Medicare members</u> currently established on a non-preferred therapy are not required to try a preferred option</small></p>

If a non-preferred product was selected above, please provide the rationale for its selection over a preferred product: _____

What type of cancer does the member have (include histology) and what stage disease?

What is the member's complete chemotherapy regimen? _____

What line of therapy is this considered (First, Second, Subsequent)? _____

What previous therapies has the member received? (Please include if the member progressed or relapsed)

What is the member's ECOG score? _____

Is the member's disease resectable or unresectable? _____

Please attach all pertinent clinical information (such as progress notes, genetic testing etc.)

Attached: YES NO

****Please verify member's eligibility and benefits through the health plan****

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