HIGHMARK WESTERN NEW YORK

Outpatient Chemotherapy
Avastin (Bevacizumab) Request Form
Fax to 833-619-5745
(Medical Benefit Only)

Member Name: _____

Member Date of Birth: _____

Member UMI: _____ ☐ Medicare ☐ Commercial

Requesting Physician's Name: _____ NPI Number: _____

Requesting Physician's Address: _____

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

Facility: _____ Facility NPI Number: _____

Facility's Address: _____

Date of Service: _____

J Code (s): _____

Diagnosis Code(s): _____

Please answer the following clinical questions:

DRUG INFORMATION (*please select one*)	
PREFERRED for ALL indications	**NON-PREFFERED****
☐ Mvasi (Q5107)	☐ Avastin (J9035)
☐ Zirabev (Q5118)	☐ Alymsys (_____)
	☐ Vegzelma (_____)
	**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
	**Medicare members currently established on a non-preferred therapy are not required to try a preferred option

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

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

Fax this completed form to Highmark at 1-833-619-5745

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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