



**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)	
<p style="text-align: center;"><u>PREFERRED for ALL indications</u></p> <p><input type="checkbox"/> Mvasi (Q5107)</p> <p><input type="checkbox"/> Zirabev (Q5118)</p>	<p style="text-align: center;"><u>NON-PREFERRED**</u></p> <p><input type="checkbox"/> Avastin (J9035)</p> <p><input type="checkbox"/> Alymsys (_____)</p> <p><input type="checkbox"/> Vegzelma (_____)</p> <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: _____

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

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

Highmark Blue Shield of Northeastern New York is a trade name of Highmark Western and Northeastern New York Inc., an independent licensee of the Blue Cross Blue Shield Association.

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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