



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

Member Name: _____

Member Date of Birth: _____

Member UMI: _____

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 all of 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) A non-preferred product will be considered when the individual has documented therapy failure after an adequate therapeutic trial of a preferred product, or the preferred product has not been tolerated or is contraindicated |

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 is the patient's cancer?

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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 patient progressed or relapsed) _____

What is the patient's ECOG score? _____

Is the disease resectable or unresectable? _____

Any additional clinical information: _____

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****

Fax this completed form to Highmark at 1-833-581-1861