SPECIALTY GUIDELINE MANAGEMENT

AVASTIN (bevacizumab)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indications

1. Metastatic colorectal cancer:
   a. In combination with intravenous 5-fluorouracil-based chemotherapy for first- or second-line treatment
   b. In combination with fluoropyrimidine-irinotecan- or fluoropyrimidine-oxaliplatin-based chemotherapy for second-line treatment in patients who have progressed on a first-line Avastin-containing regimen
2. Non-squamous non-small cell lung cancer (NSCLC), with carboplatin and paclitaxel for first line treatment of unresectable, locally advanced, recurrent or metastatic disease
3. Metastatic renal cell carcinoma with interferon alfa
4. Glioblastoma, as a single agent for adult patients with progressive disease following prior therapy
5. Cervical cancer, in combination with paclitaxel and cisplatin or paclitaxel and topotecan in persistent, recurrent, or metastatic disease
6. Recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer
   a. In combination with paclitaxel, pegylated liposomal doxorubicin or topotecan for patients with platinum-resistant disease who received no more than 2 prior chemotherapy regimens
   b. Either in combination with carboplatin and paclitaxel or in combination with carboplatin and gemcitabine, followed by Avastin as a single agent in patients with platinum-sensitive disease

B. Compendial Uses

1. Breast cancer
2. Central nervous system (CNS) cancers
   a. Adult intracranial and spinal ependymoma
   b. Anaplastic gliomas
3. Cervical cancer
4. Colon/rectal cancer
5. Endometrial cancer
6. Malignant Pleural Mesothelioma
7. Non-small cell lung cancer
8. Ovarian cancer (Malignant sex cord-stromal tumors)
9. Renal cell carcinoma
10. Soft tissue sarcoma
11. Ophthalmic disorders
   a. Diabetic macular edema
   b. Wet age-related macular degeneration (AMD)
c. Retinal vein occlusion (RVO) with macular edema
d. Proliferative diabetic retinopathy
e. Choroidal neovascularization (CNV)
f. Neovascular glaucoma; adjunct
g. Retinopathy of prematurity

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Ophthalmic disorders
   Authorization of 12 months may be granted for the following retinal disorders:
   1. Diabetic macular edema
   2. Neovascular (wet) age-related macular degeneration including subtypes:
      a. Polypoidal choroidopathy
      b. Retinal angiomatous proliferation
   3. Macular edema following retinal vein occlusion
   4. Proliferative diabetic retinopathy
   5. Choroidal neovascularization
   6. Neovascular glaucoma
   7. Retinopathy of prematurity

B. Colorectal cancer (CRC)
   Authorization of 12 months may be granted for the treatment of unresectable advanced or metastatic colorectal cancer.

C. CNS cancer
   Authorization of 12 months may be granted for treatment of the following types of CNS cancer:
   1. Glioblastoma
   2. Anaplastic glioma
   3. Adult intracranial and spinal ependymoma (excludes subependymoma)

D. NSCLC
   Authorization of 12 months may be granted for the treatment of unresectable, locally advanced, recurrent, or metastatic, non-squamous NSCLC when Avastin is used as first-line or subsequent therapy or as continuation maintenance therapy (ie, continuation of Avastin as first-line therapy beyond 4-6 cycles in the absence of disease progression).

E. Ovarian cancer
   1. Recurrent Epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer
      Authorization of 12 months may be granted for the treatment of recurrent epithelial ovarian cancer, fallopian tube cancer, and primary peritoneal cancer.
   2. Malignant sex cord-stromal tumors
      Authorization of 12 months may be granted for the treatment of malignant sex cord-stromal tumors.

F. Endometrial cancer
   Authorization of 12 months may be granted for the treatment of endometrial cancer.

G. Cervical cancer
   Authorization of 12 months may be granted for the treatment of cervical cancer.

H. Breast cancer
   Authorization of 12 months may be granted for treatment of breast cancer.
I. Renal cell carcinoma
Authorization of 12 months may be granted for the treatment of renal cell carcinoma.

J. Soft tissue sarcoma
Authorization of 12 months may be granted for the treatment of the following types of soft tissue sarcoma:
1. Angiosarcoma
2. Solitary fibrous tumor
3. Hemangiopericytoma

K. Malignant Pleural Mesothelioma
Authorization of 12 months may be granted for the treatment of malignant pleural mesothelioma.

III. CONTINUATION OF THERAPY
All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES