Avastin (for Maryland only)

Prior Authorization Request

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*ft* _____*inches*

Criteria Questions:

1. What is the ICD-10 code? _____

2. Will Avastin be administered by intravitreal injection for an ophthalmic disorder? ❑ Yes ❑ No *If No, skip to #4*

3. What is the diagnosis? *Indicate below and no further questions.*
   - ❑ Neovascular (wet) age-related macular degeneration (includes polypoidal choroidopathy and retinal angiomatous proliferation subtypes)
   - ❑ Choroidal neovascularization (CNV) due to high (pathologic) myopia
   - ❑ Choroidal/ocular neovascularization due to ocular histoplasmosis syndrome
   - ❑ CNV due to angioid streaks
   - ❑ CNV due to an inflammatory condition
   - ❑ Idiopathic CNV
   - ❑ Ocular neovascularization (choroidal, retinal, iris) due to proliferative diabetic retinopathy, *no further questions*
   - ❑ Diabetic macular edema
   - ❑ Macular edema due to retinal vein occlusion (RVO)
   - ❑ Retinopathy of prematurity
   - ❑ Neovascular glaucoma as adjunct
   - ❑ Proliferative diabetic retinopathy (as adjunct prior to vitrectomy)
   - ❑ Other _____

4. What is the diagnosis?
   - ❑ Colon cancer
   - ❑ Rectal cancer
   - ❑ Central nervous system (CNS) cancer
   - ❑ Non-small cell lung cancer (NSCLC)
   - ❑ Ovarian cancer
   - ❑ Cervical cancer
   - ❑ Breast cancer
   - ❑ Renal cell carcinoma
   - ❑ Soft tissue sarcoma
   - ❑ Endometrial cancer
   - ❑ Malignant pleural mesothelioma
   - ❑ Other _____

5. Would the prescriber like to request an override of the step therapy requirement? ❑ Yes ❑ No *If No, skip to #8*

6. Has the member received the medication through a pharmacy or medical benefit within the past 180 days?
❑ Yes ❑ No ACTION REQUIRED: ***Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e. PBM medication history, pharmacy receipt, EOB etc.)***

7. Is the medication effective in treating the member's condition? ❑ Yes ❑ No *Continue to #8 and complete this form in its entirety.*

8. What is the prescribed chemotherapy regimen? _____

9. Is the disease any of the following? ***Check all that apply.***
❑ Recurrent ❑ Metastatic ❑ Persistent
❑ Unresectable ❑ Locally advanced ❑ Other _____

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Breast Cancer

10. What is the HER2 status? ***ACTION REQUIRED: Attach HER2 status test results.***
❑ Positive ❑ Negative ❑ Unknown

Section B: Central Nervous System (CNS) Cancer

11. What is the tumor type of CNS cancer?
❑ Anaplastic glioma ❑ Adult intracranial and spinal ependymoma (excludes subependymoma)
❑ Glioblastoma ❑ Other _____

Section C: Endometrial Cancer

12. Has the disease progressed on prior cytotoxic chemotherapy? ❑ Yes ❑ No

Section D: Ovarian Cancer

13. What is the subtype of ovarian cancer?
❑ Epithelial ovarian cancer ❑ Primary peritoneal cancer
❑ Fallopian tube cancer ❑ Malignant sex cord-stromal tumors, *skip to #17*
❑ Other _____

14. Is the disease platinum-sensitive or platinum-resistant?
❑ Platinum-sensitive, *skip to #16* ❑ Platinum-resistant

15. How many prior chemotherapy regimens has the patient received in the past? _____

16. Has the patient received a prior treatment with Avastin for persistent or recurrent disease?
❑ Yes ❑ No *No further questions*

17. Does the patient have granulosa cell tumors? ❑ Yes ❑ No

18. Has the patient had a clinical relapse? ❑ Yes ❑ No

Section E: Renal Cell Carcinoma

19. In what clinical setting is Avastin being used?
❑ For relapse ❑ For surgically unresectable disease ❑ Other _____

20. What is the intent of the treatment?
❑ First-line therapy ❑ Subsequent therapy ❑ Other _____

21. What is the histology of the disease? ***ACTION REQUIRED: Attach a copy of the histology report.***
❑ Non-clear cell histology ❑ Predominant clear cell histology ❑ Other _____

22. Will Avastin be given following prior cytokine therapy? ❑ Yes ❑ No

Section F: Soft Tissue Sarcoma

23. What is the subtype of soft tissue sarcoma?
❑ Angiosarcoma ❑ Hemangiopericytoma
❑ Solitary fibrous tumor ❑ Other _____

Section G: Non-Small Cell Lung Cancer (NSCLC)

24. Does the disease express non-squamous cell histology? ***ACTION REQUIRED: Attach a copy of histology report.***
❑ Yes ❑ No

25. Is there a history of recent hemoptysis? ❑ Yes ❑ No

26. What is the intent of treatment?
❑ First line therapy, *skip to #31*
❑ Subsequent therapy (i.e., second-line therapy and beyond)
❑ Continuation maintenance therapy (i.e., continuation of treatment with Avastin as first-line therapy beyond 4-6 cycles), *skip to #29*
❑ Other _____

27. Has the patient received prior treatment with erlotinib, afatinib, gefitinib or crizotinib? ❑ Yes ❑ No

28. Does the patient have distant metastases or locoregional recurrence with evidence of disseminate disease?
❑ Yes ❑ No *No further questions*

29. What is the patient's EGFR mutation status? ***ACTION REQUIRED: Attach EGFR mutation status test results.***
❑ Positive ❑ Negative ❑ Unknown

30. What is the patient's ALK rearrangement test result?
ACTION REQUIRED: Attach ALK rearrangement test results. ❑ Positive ❑ Negative ❑ Unknown

31. Was Avastin previously used with a first-line pemetrexed/platinum chemotherapy regimen? ❑ Yes ❑ No

32. Has the patient achieved tumor response following first-line chemotherapy?
If Yes, no further questions ❑ Yes ❑ No

33. Is the disease stable following first-line chemotherapy? ❑ Yes ❑ No

<u>Section H: Colorectal Cancers</u>

34. In what clinical setting is Avastin being used?
❑ Neoadjuvant therapy ❑ Adjuvant therapy
❑ Postoperative therapy ❑ Other _____

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**