



Fax completed form to: (855) 840-1678  
 If this is an URGENT request, please call (800) 882-4462 (800.88.CIGNA)

## Almysys (bevacizumab-maly) Avastin (bevacizumab)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:		* Date of Birth:
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		
<b>Urgency:</b> <input type="checkbox"/> Standard <span style="margin-left: 200px;"><input type="checkbox"/> Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)</span>					
<b>Medication Requested:</b> <input type="checkbox"/> Avastin <span style="margin-left: 100px;"><input type="checkbox"/> Almysys</span> Is this a new start? <input type="checkbox"/> Yes <input type="checkbox"/> No <span style="margin-left: 100px;">Start date:</span> Dose: <span style="margin-left: 100px;">Frequency of therapy:</span> <span style="margin-left: 100px;">Duration of therapy:</span> Will this medication be given concurrently with other agents? <input type="checkbox"/> Yes <input type="checkbox"/> No <span style="margin-left: 100px;">If yes, please specify:</span> What is your patient's current weight? <span style="margin-left: 100px;">ICD10:</span>					
<b>Where will this medication be obtained?</b> <input type="checkbox"/> Accredo Specialty Pharmacy** <span style="margin-left: 300px;"><input type="checkbox"/> Retail pharmacy</span> <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <span style="margin-left: 300px;"><input type="checkbox"/> Home Health / Home Infusion vendor</span> <input type="checkbox"/> Other (please specify): <span style="margin-left: 300px;">**Cigna's nationally preferred specialty pharmacy</span>					
<i>**Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822   NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557</i>					
<b>Facility and/or doctor dispensing and administering medication:</b> Facility Name: <span style="margin-left: 150px;">State:</span> <span style="margin-left: 150px;">Tax ID#:</span> Address (City, State, Zip Code):					
<b>NOTE:</b> Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting					
Is this infusion occurring in a facility affiliated with hospital outpatient setting? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>					
If yes- Is this patient a candidate for re-direction to an alternate setting (such as AIS, MDO, home) with assistance of a Specialty Care Option Case Manager? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No (provide medical necessity rationale):</span>					
<b>Is your patient a candidate for home infusion?</b> <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span> <b>Does the physician have an in-office infusion site?</b> <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span>					
Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>					
<b>Diagnosis:</b> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> AIDS-related Kaposi sarcoma (KS)  <input type="checkbox"/> Ampullary adenocarcinoma  <input type="checkbox"/> angiosarcoma  <input type="checkbox"/> cervical cancer (carcinoma of the cervix)  <input type="checkbox"/> colon or rectal cancer (colorectal cancer, CRC)  <input type="checkbox"/> non-small cell lung cancer (NSCLC)  <input type="checkbox"/> endometrial cancer  <input type="checkbox"/> epithelial ovarian cancer (including serous, mucinous, endometrioid, clear-cell, Brenner or transitional cell)  <input type="checkbox"/> hepatocellular carcinoma (HCC)  <input type="checkbox"/> small bowel adenocarcinoma  <input type="checkbox"/> other (please specify):         </div> <div style="width: 50%;"> <input type="checkbox"/> fallopian tube cancer  <input type="checkbox"/> granulosa cell ovarian cancer  <input type="checkbox"/> CNS/brain tumor  <input type="checkbox"/> pleural mesothelioma  <input type="checkbox"/> primary peritoneal cancer  <input type="checkbox"/> radiation necrosis and uncontrolled cerebral edema  <input type="checkbox"/> renal cell cancer (RCC)  <input type="checkbox"/> solitary fibrous tumor/hemangiopericytoma  <input type="checkbox"/> vulvar squamous cell carcinoma         </div> </div>					

(if CNS/brain tumor) What is your patient's diagnosis?

- anaplastic glioma (including anaplastic astrocytoma, anaplastic oligodendroglioma and anaplastic oligoastrocytoma)
- central nervous system (CNS) brain metastases
- central nervous system (CNS) meningioma
- ependymoma
- glioblastoma (including glioblastoma multiforme)
- leptomeningeal metastases
- medulloblastoma
- primary central nervous system (CNS) lymphoma
- subependymoma
- spine tumor
- other (please specify):

(if other to either question above) Is this use related to chemotherapy or oncology (cancer)?

Yes  No

### Clinical Information

(if NSCLC) Does your patient have non-squamous cell NSCLC?

Yes  No

(if NSCLC) Does your patient have unresectable, locally advanced, recurrent, or metastatic disease?

Yes  No

(if NSCLC) Is the drug requested being given as first-line therapy?

- Yes
- No

(if first-line) Will the drug requested be given in combination with carboplatin and paclitaxel?

Yes  No

(if pleural mesothelioma) Will the drug requested be used in combination with pemetrexed (Alimta, Pemfexy) and EITHER cisplatin or Paraplatin (carboplatin)?

Yes  No

(if pleural mesothelioma) What is your patient's stage?

- stage 1 (I)-stage 3a (IIIa)
- stage 3b (IIIb)-stage 4 (IV)
- Other

(if stage 1-3a) Does your patient have unresectable disease?

Yes  No

(if not unresectable OR Other stage) Does your patient have medically inoperable tumors?

Yes  No

(if inoperable tumors) What is your patient performance status?

- PS 0-2
- PS 3-4

(if cervical) Does your patient have persistent, recurrent, or metastatic disease?

Yes  No

(if cervical) Will the drug requested be used in combination with paclitaxel and either cisplatin or carboplatin OR paclitaxel and topotecan (Hycamtin)?

Yes  No

(if CRC or spine tumor) Does your patient have metastatic disease?

Yes  No

(if CRC) How is the drug requested being used in your patient's treatment?

- in combination with a fluorouracil (Adrucil, 5-FU) based chemotherapy regimen
- in combination with fluoropyrimidine-irinotecan (Camptosar)- OR fluoropyrimidine-oxaliplatin-based chemotherapy
- In combination with trifluridine and tipiracil (Lonsurf)
- other

(if in combo with Lonsurf chemo) Is this medication being used as second-line treatment in patients who have been previously treated with fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy, an anti-VEGF biological therapy, AND if RAS wild-type, an anti-EGFR therapy?

Yes  No

(if in combo with 5-FU chemo) Is this medication being used as a first or second-line therapy?

Yes  No

(if in combo with fluoropyrimidine-irinotecan- or fluoropyrimidine-oxaliplatin-based chemo) Did your patient have disease progression while on a first-line bevacizumab (Alymsys, Avastin, Mvasi, Vegzelma, and Zirabev)-containing regimen?

Yes  No

(if endometrial) Which of the following best describes the requested drug's role in your patient's therapy?

- for disease progression after failure of first-line therapy
- for the treatment of advanced or recurrent disease
- other

(if advanced or recurrent) Will the drug requested be used in combination with carboplatin and paclitaxel?

Yes  No

(if HCC) Does your patient have unresectable or metastatic disease?

Yes  No

(if HCC) Will the requested drug be used in combination with Tecentriq (atezolizumab)?

Yes  No

(if HCC) Has the patient received prior systemic therapy for this diagnosis in the past?

Yes  No

(if RCC) Does your patient have relapsed or metastatic disease?

Yes  No

(if RCC) What is the histology of the disease?

- non-clear cell
- predominantly clear cell
- other

(if non-clear) Does your patient have advanced papillary renal cell carcinoma [RCC] (including hereditary leiomyomatosis and renal

cell cancer [HLRCC])? Yes  No

(if yes) Will the drug requested be used in combination with Afinitor (everolimus) or Tarceva (erlotinib)? Yes  No

(if predominant clear cell) Which best describes how the drug requested will be used?

- as first-line therapy  
 following disease progression while on previous therapy  
 neither of the above

(if non-clear or after disease progression with clear cell) Will the drug requested be used as single-agent therapy? Yes  No

(if predominant clear cell and first-line) Will the drug requested be used in combination with interferon alfa-2b (Intron-A)? Yes  No

(if granulosa cell ovarian) Does your patient have relapsed disease? Yes  No

(if yes) What is the patient's cancer stage?

- Stage 1 (I)  
 Stage 2 (II)  
 Stage 3 (III)  
 Stage 4 (IV)

(if angiosarcoma, CNS brain mets, endometrial, ependymoma, granulosa cell ovarian, lep mets, medulloblastoma, primary CNS lymphoma, spine tumor, radiation necrosis and uncontrolled cerebral edema) Will the drug requested be used as single-agent therapy? Yes  No

(if anaplastic glioma or glioblastoma) Does your patient have recurrent disease? Yes  No

(if ependymoma) Does the patient have progressive disease? Yes  No

(if CNS meningioma) Does your patient have recurrent or progressive disease? Yes  No

(if CNS meningioma) Is the lesion surgically inaccessible (meaning that standard surgical techniques can't reach it)? Yes  No

(if CNS meningioma) Is radiation a possible option? Yes  No

(if CNS brain mets, lep mets, or spine tumor) Is the drug requested being given to control symptoms? Yes  No

(if solitary fibrous tumor/hemangiopericytoma) Will the drug requested be used in combination with Temodar (temozolomide)? Yes  No

(if epithelial ovarian, fallopian tube, peritoneal) Is your patient's cancer associated with homologous recombination deficiency (HRD) positive status? Yes  No

(if HRD positive) Did the patient have gene testing showing genomic instability AND/OR a deleterious or suspected deleterious BRCA mutation? Yes  No

(if yes) Has your patient had a complete or partial response to first-line platinum-based chemotherapy (carboplatin or cisplatin)? Yes  No

(if complete or partial response) Will the requested drug be used for first-line maintenance treatment? Yes  No

(if first-line maintenance) Does your patient have advanced disease? Yes  No

(if advanced disease) Will the requested drug be used in combination with Lynparza (olaparib)? Yes  No

(if epithelial ovarian, fallopian tube, or primary peritoneal and not to ANY of the previous 6 questions) Does your patient have stage III or IV disease? Yes  No

(if stage III or IV) Has your patient had surgical resection? Yes  No

(if resection) Will/Was the drug requested used in combination with carboplatin and paclitaxel, followed by single-agent therapy with bevacizumab (Alymsys, Avastin, Mvasi, Zirabev)? Yes  No

(if no to any of the previous 3 questions) Does your patient have persistent or recurrent disease? Yes  No

(if persistent or recurrent) Has your patient been treated with bevacizumab (Alymsys, Avastin, Mvasi, Zirabev) before? Yes  No

(if treated with bevacizumab before) Is your patient currently on bevacizumab (Alymsys, Avastin, Mvasi, or Zirabev) for this diagnosis? Yes  No

(if no bevacizumab before OR currently on) Will the drug requested be used as single-agent therapy? Yes  No

(if not single agent) Was your patient previously treated with carboplatin or cisplatin (platinum therapy)?

- Yes, and patient was platinum-refractory (no response with progression during treatment)  
 Yes, and patient was platinum-resistant (showed initial response to chemotherapy but relapsed within 6 months of last round of chemotherapy)  
 Yes, and patient was platinum-sensitive  
 No, patient was not treated with platinum therapy

(if platinum-sensitive) Will the drug requested be used in combination with EITHER paclitaxel and carboplatin OR gemcitabine (Gemzar) and carboplatin? Yes  No

(if platinum-resistant) Will the drug requested be used in combination with liposomal doxorubicin (Doxil or Lipodox), paclitaxel OR topotecan (Hycamtin)? Yes  No

(if epithelial ovarian) Which type of epithelial tumor does your patient have?

- serous or endometrioid
- mucinous
- clear cell
- other

(if serous/endometrioid or mucinous) Will the drug requested be used as adjuvant therapy? Yes  No

(if mucinous and NOT adjuvant) Does your patient have persistent or recurrent disease? Yes  No

(if serous/endometrioid) What is the tumor grade?

- grade 1
- grade 2
- grade 3
- unknown

(if serous/endometrioid, mucinous, or granulosa cell) What is your patient's cancer stage?

- Stage 1 (I)
- Stage 2 (II)
- Stage 3 (III)
- Stage 4 (IV)

(if serous/endometrioid, adjuvant, and stage II/III/IV) Will the drug requested be used in combination with carboplatin and paclitaxel? Yes  No

(if mucinous, adjuvant and stage II/III/IV) Is the drug requested being used as any of the following?

- as combination therapy with carboplatin or paclitaxel
- as combination therapy with capecitabine (Xeloda) and oxaliplatin
- as combination therapy with fluorouracil (Acrucil, 5-FU), leucovorin, and oxaliplatin
- none of the above

(if mucinous and persistent or recurrent) Is the drug requested being used as any of the following?

- as combination therapy with fluorouracil (Acrucil, 5-FU), leucovorin, and oxaliplatin
- as combination therapy with capecitabine (Xeloda) and oxaliplatin
- neither of the above

(if small bowel adenocarcinoma) Will this drug be used in combination with either a Xeloda (capecitabine) or a 5-fluorouracil (5-FU) regimen? Yes  No

(if small bowel adenocarcinoma) Does the patient have advanced or metastatic disease? Yes  No

(if small bowel adenocarcinoma) Will the patient be using this medication as initial therapy? Yes  No

(if no) Will the patient be using this medication as subsequent therapy in patients who previously received initial therapy with Opdivo (nivolumab)? Yes  No

(if vulvar squamous cell carcinoma) Will the drug requested be used in combination with paclitaxel and EITHER cisplatin or Paraplatin (carboplatin)? Yes  No

(if vulvar squamous cell carcinoma) Which best describes your patient's diagnosis?

- unresectable locally advanced disease with residual tumor at primary site
- locally advanced disease with positive margins following resection
- as primary treatment for metastatic disease beyond the pelvis
- for isolated groin/pelvic recurrence if prior external beam radiation therapy (EBRT)
- for clinical nodal or distant recurrence with multiple pelvic nodes, distant metastasis, or prior pelvic EBRT
- other

Is documentation being provided that the patient has tried BOTH Mvasi (bevacizumab-awwb) and Zirabev (bevacizumab-bvzr) [both of which may require prior authorization]? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. Yes  No

Is the patient unable to continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) (for example, differences in stabilizing agent, buffering agent, and/or surfactant) which, according to the prescriber, would result in a significant allergy or serious adverse reaction? Yes  No

**Additional pertinent information:** *(including disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently)*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005