



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

**Mvasi (bevacizumab-awwb)**  
**Vegzelma (bevacizumab-adcd)**  
**Zirabev (bevacizumab-bvzr)**

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 <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)					
<b>Medication Requested:</b> <input type="checkbox"/> Mvasi 100mg/4ml <input type="checkbox"/> Zirabev 100mg/4ml <input type="checkbox"/> Vegzelma 100mg/4ml <input type="checkbox"/> Mvasi 400mg/16ml <input type="checkbox"/> Zirabev 400mg/16ml <input type="checkbox"/> Vegzelma 400mg/16ml					
Dose: _____ Frequency of therapy: _____ Duration of therapy: _____ What is your patient's current weight? _____					
Is this a new start or continuation of therapy? If your patient has already begun treatment with samples of the requested medication, please choose new start of therapy. <input type="checkbox"/> New start <input type="checkbox"/> Continuation of therapy					
<b>Facility and/or doctor dispensing and administering medication:</b> Facility Name: _____ State: _____ Tax ID#: _____ 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? <input type="checkbox"/> Yes <input type="checkbox"/> No 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? <input type="checkbox"/> Yes <input type="checkbox"/> No (provide medical necessity rationale): _____					
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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Diagnosis related to use?</b> <input type="checkbox"/> ampullary adenocarcinoma <input type="checkbox"/> anaplastic glioma (including astrocytoma, oligodendroglioma, oligoastrocytoma) <input type="checkbox"/> cervical cancer <input type="checkbox"/> CNS brain metastases <input type="checkbox"/> colorectal cancer (CRC) <input type="checkbox"/> endometrial cancer <input type="checkbox"/> ependymoma (EXCLUDES subependymoma) <input type="checkbox"/> epithelial ovarian cancer (includes serous, mucinous, endometrioid, clear-cell, Brenner, or transitional cell) <input type="checkbox"/> fallopian tube cancer <input type="checkbox"/> glioblastoma <input type="checkbox"/> granulosa cell ovarian cancer <input type="checkbox"/> hepatocellular carcinoma (HCC) <input type="checkbox"/> medulloblastoma <input type="checkbox"/> non-small cell lung cancer (NSCLC) <input type="checkbox"/> pleural mesothelioma					

- primary peritoneal cancer
- radiation necrosis and uncontrolled cerebral edema
- renal cell cancer (RCC)
- small bowel adenocarcinoma
- solitary fibrous tumor/hemangiopericytoma
- spine tumors
- vulvar squamous cell carcinoma
- other (please specify):

(if other) Is this use related to chemotherapy or oncology (cancer)? Yes  No

**Clinical Information**

(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) 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 (Aducil, 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 5-FU chemo) Is the medication requested 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 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 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/unknown

(if advanced or recurrent) Will the requested drug be used in combination with carboplatin and paclitaxel? Yes  No

(if ependymoma, primary CNS lymphoma, medulloblastoma, endometrial, after first-line failure OR granulosa cell ovarian, radiation necrosis and uncontrolled cerebral edema) Will the requested drug be used as single-agent therapy? Yes  No

(if epithelial ovarian, fallopian tube, or primary peritoneal) Does the patient have ADVANCED disease? Yes  No

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

(if with Lynparza) Will the requested drug be used for first-line maintenance treatment? Yes  No

(if first-line maintenance) 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) Is the 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 epithelial ovarian, fallopian tube, or primary peritoneal and no to any of the previous 6 questions) Does your patient have stage III (3) or IV (4) disease? Yes  No

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

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

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

(if NOT stage III/IV OR no surgical resection OR not in combo with carboplatin and paclitaxel followed by single-agent bevacizumab) Has your patient been treated with bevacizumab (Avastin, Mvasi, or Zirabev) before? Yes  No

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

(if no bevacizumab before OR currently on it for this diagnosis) Will the requested drug 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
- Unknown

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

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

(if epithelial ovarian) Which subtype of epithelial ovarian cancer does your patient have?

- serous or endometrioid
- mucinous
- clear cell
- unknown or other

(if serous/endometrioid or mucinous) Will the requested drug 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)
- unknown

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

(if mucinous, adjuvant and stage II/III/IV) Is the requested drug 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 (Aducil,5-FU), leucovorin, and oxaliplatin
- none of the above

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

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

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

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

(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, patient has tried other drugs before for this diagnosis
- Unknown

(if first-line) Will the drug requested be given in combination with carboplatin and paclitaxel? Yes  No

(if pleural mesothelioma) Will the requested drug be used in combination with Alimta (pemetrexed) 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)
- unknown

(if Stage 1-3a) Does your patient have unresectable disease? Yes  No

(if not unresectable or unknown stage) Does your patient have medically inoperable tumors? Yes  No

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

- PS 0-2
- PS 3-4
- unknown

(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 advanced papillary RCC) 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 requested drug will be used?

- as first-line therapy  
 used 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 first-line) Will the drug requested be used in combination with Intron-A? Yes  No

(if vulvar squamous cell carcinoma) Will the requested drug 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

(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 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 drug as initial therapy? Yes  No

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

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

(if spine tumors) Does the patient have metastatic disease? Yes  No

(if CNS brain metastases, spine tumors) Will this drug be used as a single agent to control symptoms? Yes  No

(if CNS meningiomas) Does the patient have surgically inaccessible recurrent or progressive disease? Yes  No

(if CNS meningiomas) Is radiation possible? Yes  No

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

(if the requested medication is Vegzelma) Is documentation being provided that the patient has tried BOTH of the following: Mvasi (bevacizumab-awwb) [may require prior authorization] AND Zirabev (bevacizumab-bvzr) [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

(if the requested medication is Vegzelma) Is documentation being provided that the patient cannot 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? 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

**Additional pertinent information** (please include 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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