Fax completed form to: (855) 840-1678
If this is an URGENT request, please call
(800) 882-4462 (800 88 CIGNA)

Jobevne
(bevacizumab-nwgd)

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:		

Urgency:
☐ Standard ☐ 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)

Medication requested:
☐ Jobevne 25mg/ml vial

Dose: Frequency of therapy: J-Code:

Duration of therapy: ICD10:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)
***Cigna's nationally preferred specialty pharmacy*

***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*

Facility and/or doctor dispensing and administering medication:

Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is your patient a candidate for home infusion? ☐ Yes ☐ No

Does the physician have an in-office infusion site? ☐ Yes ☐ No

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? ☐ Yes ☐ No

What is the patient's diagnosis or reason for treatment?

☐ Angiosarcoma
☐ Cervical cancer
☐ Colon or rectal cancer
☐ Endometrial cancer
☐ Epithelial ovarian cancer (includes serous, mucinous, endometrioid, clear-cell, Brenner, or transitional cell)
☐ Fallopian tube cancer
☐ Glioblastoma (including glioblastoma multiforme)
☐ Granulosa cell ovarian cancer
☐ Hepatocellular carcinoma (HCC)
☐ Medulloblastoma
☐ Non-small cell lung cancer (NSCLC)
☐ Pleural mesothelioma
☐ Primary peritoneal cancer
☐ Small bowel adenocarcinoma
☐ Solitary fibrous tumor/hemangiopericytoma
☐ Vulvar Squamous cell carcinoma
☐ other

Clinical Information:

(if Glioblastoma) Does the patient have recurrent disease? ☐ Yes ☐ No

(if NSCLC) Does the patient have non-squamous cell NSCLC? ☐ Yes ☐ No

(if NSCLC) Does the patient have unresectable, locally advanced, recurrent, or metastatic disease? ☐ Yes ☐ No

(if NSCLC) Is the requested medication being given as first-line therapy?
☐ Yes
☐ No, patient has tried other drugs before for this diagnosis

(if NSCLC) Will the requested medication be given in combination with carboplatin and paclitaxel? ☐ Yes ☐ No

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

(if Small bowel adenocarcinoma) Is the requested medication being used as any of the following?
☐ As combination therapy with a 5-FU regimen
☐ As combination therapy with capecitabine
☐ Neither of the above

(if Small bowel adenocarcinoma) Is the requested medication being given as part of initial therapy?
☐ Yes
☐ No, patient has tried other drugs before for this diagnosis

(if Small bowel adenocarcinoma) Was the patient previously treated with nivolumab as initial treatment?
☐ Yes, in combination with ipilimumab
☐ Yes, in combination with pembrolizumab
☐ Yes, without either ipilimumab or pembrolizumab
☐ No, patient was not treated with nivolumab

(if Cervical cancer) Does the patient have persistent, recurrent, or metastatic disease? ☐ Yes ☐ No

(if Cervical cancer) Will the requested medication be used in combination with either: a) paclitaxel and cisplatin or carboplatin; OR b) paclitaxel and topotecan? ☐ Yes ☐ No

(if Colon or rectal cancer) Does the patient have metastatic disease? ☐ Yes ☐ No

(if Colon or rectal cancer) How is the requested medication being used in the patient's treatment?
☐ In combination with 5-FU based chemotherapy regimen
☐ In combination with fluoropyrimidine-irinotecan- OR fluoropyrimidine-oxaliplatin-based chemotherapy
☐ In combination with trifluridine and tipiracil (Lonsurf)
☐ Other

(if Colon or rectal cancer, In combination with 5-FU based chemotherapy regimen) Is the requested medication being used as a first or second-line therapy? ☐ Yes ☐ No

(if Colon or rectal cancer, In combination with fluoropyrimidine-irinotecan- OR fluoropyrimidine-oxaliplatin-based chemotherapy) Is the requested medication being used as second-line treatment? ☐ Yes ☐ No

(if Colon or rectal cancer, In combination with fluoropyrimidine-irinotecan- OR fluoropyrimidine-oxaliplatin-based chemotherapy) Did the patient have progression while on a first-line bevacizumab-containing regimen? ☐ Yes ☐ No

(if Colon or rectal cancer, In combination with trifluridine and tipiracil (Lonsurf)) Is the requested 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 cancer) Which of the following best describes the requested medication's role in the patient's therapy?
☐ For disease progression after failure of first-line therapy
☐ For the treatment of advanced or recurrent disease
☐ Other

(if endometrial cancer, advanced or recurrent) Will the requested medication be used in combination with carboplatin and paclitaxel? ☐ Yes ☐ No

(if Granulosa cell ovarian cancer) Does the patient have relapsed disease? ☐ Yes ☐ No

(if Granulosa cell ovarian cancer) What is the patient's cancer stage?
☐ Stage 1 (I) ☐ Stage 2 (II) ☐ Stage 3 (III) ☐ Stage 4 (IV)

(if Solitary fibrous tumor/hemangiopericytoma) Will the requested medication be used in combination with temozolomide? ☐ Yes ☐ No

(if Epithelial ovarian cancer (includes serous, mucinous, endometrioid, clear-cell, Brenner, or transitional cell)) Does the patient have any of the following epithelial ovarian cancer subtypes?
☐ Serous or endometrioid
☐ Mucinous
☐ Clear cell
☐ No or Other

(if Epithelial ovarian cancer, serous) What is the tumor grade?
☐ Grade 1 ☐ Grade 2 ☐ Grade 3

(if Epithelial ovarian cancer, serous)) What is the patient's cancer stage?
☐ Stage 1 (I) ☐ Stage 2 (II) ☐ Stage 3 (III) ☐ Stage 4 (IV)

(if Epithelial ovarian cancer, serous) Will the requested medication be used as adjuvant therapy? ☐ Yes ☐ No

(if Epithelial ovarian cancer, serous) Will the requested medication be used in combination with carboplatin and paclitaxel? ☐ Yes ☐ No

(if Epithelial ovarian cancer, mucinous) Will the requested medication be used as adjuvant therapy? ☐ Yes ☐ No

(if Epithelial ovarian cancer, mucinous) What is the patient's cancer stage?
☐ Stage 1 (I) ☐ Stage 2 (II) ☐ Stage 3 (III) ☐ Stage 4 (IV)

(if Epithelial ovarian cancer, mucinous) Is the requested medication being used as any of the following?
☐ As combination therapy with carboplatin and paclitaxel
☐ As combination therapy with capecitabine and oxaliplatin
☐ As combination therapy with fluorouracil, leucovorin, and oxaliplatin
☐ None of the above

(if Epithelial ovarian cancer, mucinous) Does the patient have persistent or recurrent disease? ☐ Yes ☐ No

(if Epithelial ovarian cancer, mucinous) Is the requested medication being used as any of the following?
☐ As combination therapy with fluorouracil, leucovorin, and oxaliplatin
☐ As combination therapy with capecitabine and oxaliplatin
☐ Neither of the above

(if Epithelial ovarian cancer, Fallopian tube cancer, Primary peritoneal cancer) Does the patient have stage III (3) or IV (4) disease? ☐ Yes ☐ No

(if Epithelial ovarian cancer, Fallopian tube cancer, Primary peritoneal cancer) Has the patient had surgical resection? ☐ Yes ☐ No

(if Epithelial ovarian cancer, Fallopian tube cancer, Primary peritoneal cancer) Will the requested medication be used in combination with carboplatin and paclitaxel, followed by single agent therapy with bevacizumab? ☐ Yes ☐ No

(if Epithelial ovarian cancer, Fallopian tube cancer, Primary peritoneal cancer) Does the patient have advanced, persistent or recurrent disease?
☐ Advanced disease
☐ Persistent or recurrent disease
☐ Neither of the above

(if Epithelial ovarian cancer, Fallopian tube cancer, Primary peritoneal cancer) Has the patient been treated with bevacizumab before this regimen? ☐ Yes ☐ No

(if Epithelial ovarian cancer, Fallopian tube cancer, Primary peritoneal cancer) Will the requested medication be used as single-agent therapy? ☐ Yes ☐ No

(if Epithelial ovarian cancer, Fallopian tube cancer, Primary peritoneal cancer) Was the 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 Epithelial ovarian cancer, Fallopian tube cancer, Primary peritoneal cancer, platinum sensitive) Will the requested medication be used in combination with EITHER paclitaxel and carboplatin OR gemcitabine and carboplatin? ☐ Yes ☐ No

(if Epithelial ovarian cancer, Fallopian tube cancer, Primary peritoneal cancer, platinum sensitive, showed initial response) Will the requested medication be used in combination with liposomal doxorubicin, paclitaxel OR topotecan? ☐ Yes ☐ No

(if Epithelial ovarian cancer, Fallopian tube cancer, Primary peritoneal cancer, advanced) Is the requested medication being given as first-line therapy?
☐ Yes
☐ No, patient has tried other drugs before for this diagnosis

(if Epithelial ovarian cancer, Fallopian tube cancer, Primary peritoneal cancer, advanced) Will the requested medication be used as maintenance therapy? ☐ Yes ☐ No

(if Epithelial ovarian cancer, Fallopian tube cancer, Primary peritoneal cancer, advanced) Will the requested medication be given in combination with olaparib? ☐ Yes ☐ No

(if Epithelial ovarian cancer, Fallopian tube cancer, Primary peritoneal cancer, advanced) Has the patient previously been treated with first-line platinum-based chemotherapy? ☐ Yes ☐ No

(if Epithelial ovarian cancer, Fallopian tube cancer, Primary peritoneal cancer, advanced) Did the patient have a complete or partial response to the first-line platinum-based chemotherapy? ☐ Yes ☐ No

(if Epithelial ovarian cancer, Fallopian tube cancer, Primary peritoneal cancer, advanced) Did the patient undergo BRCA gene testing? Yes No
(if Epithelial ovarian cancer, Fallopian tube cancer, Primary peritoneal cancer, advanced) Is the patient's cancer associated with homologous recombination deficiency positive status defined by either a deleterious or suspected deleterious BRCA mutation, and/or genomic instability? ☐ Yes ☐ No

(if Pleural mesothelioma) Will the requested medication be used in combination with pemetrexed and either cisplatin or carboplatin? ☐ Yes ☐ No
(if Pleural mesothelioma) What is the patient's cancer stage?
☐Stage 1 (I) - Stage 3a (IIIa)
☐Stage 3b (IIIb) - Stage 4 (IV)
☐Other

(if Pleural mesothelioma) Does the patient have unresectable disease? ☐ Yes ☐ No

(if Pleural mesothelioma) Does the patient have medically inoperable tumors? ☐ Yes ☐ No

Q62. (if Pleural mesothelioma) What is the patient's performance status?
☐ 0-2 ☐ 3-4

(if Vulvar Squamous cell carcinoma) Will the requested medication be used in combination with paclitaxel and either cisplatin or carboplatin? ☐ Yes ☐ No

(if Vulvar Squamous cell carcinoma) Which best describes the 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

(if Hepatocellular carcinoma (HCC)) Does the patient have unresectable or metastatic disease? ☐ Yes ☐ No

(if Hepatocellular carcinoma (HCC)) Will the requested medication be used in combination with atezolizumab? ☐ Yes ☐ No

(if Hepatocellular carcinoma (HCC)) Has the patient previously received any systemic therapy? ☐ Yes ☐ No

(if Angiosarcoma, Endometrial cancer, Granulosa cell ovarian cancer, Medulloblastoma) Will the requested medication be used as single-agent therapy? ☐ Yes ☐ No

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.
Notes: Please Note: A "yes" answer must be reviewed by a member of the UMP/nurse team. ☐ Yes ☐ No

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.
Notes: Please Note: A "yes" answer must be reviewed by a member of the UMP/nurse team ☐ Yes ☐ No

Additional pertinent information:

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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