Cigna®

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:		

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: ICD10:
☐ Mvasi 100mg/4ml ☐ Zirabev 100mg/4ml ☐ Vegzelma 100mg/4ml
☐ Mvasi 400mg/16ml ☐ Zirabev 400mg/16ml ☐ 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.
☐ New start
☐ Continuation of therapy

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

***NOTE:** 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? ☐ Yes ☐ 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? ☐ Yes ☐ 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? ☐ Yes ☐ No

Diagnosis related to use?
☐ ampullary adenocarcinoma
☐ anaplastic glioma (including astrocytoma, oligodendroglioma, oligoastrocytoma)
☐ cervical cancer
☐ CNS brain metastases
☐ colorectal cancer (CRC)
☐ endometrial cancer
☐ ependymoma (EXLUDES subependymoma)
☐ epithelial ovarian cancer (includes serous, mucinous, endometrioid, clear-cell, Brenner, or transitional cell)
☐ fallopian tube cancer
☐ glioblastoma
☐ granulosa cell ovarian cancer
☐ hepatocellular carcinoma (HCC)
☐ medulloblastoma
☐ non-small cell lung cancer (NSCLC)
☐ 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 (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 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 (Adrucil,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 (Adrucil, 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 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 requested medication is Vegzelma) The covered alternatives are: Mvasi (bevacizumab-awwb) and Zirabev (bevacizumab-bvzr). For the alternatives tried, please include medication name and strength, date(s) taken and for how long, and what the documented results were of taking each medication, including any intolerances or adverse reactions your patient experienced.

(if requested medication is Vegzelma) For Mvasi (bevacizumab-awwb), which of the following applies to your patient?
☐ Patient has not tried this medication
☐ Patient tried this medication, but it didn't work or didn't work well enough.
☐ Patient tried this medication, but had an allergic or adverse reaction.
☐ Other

(if allergic or adverse reaction to Mvasi) Is there documentation that this reaction was due to a formulation difference in the inactive ingredients between the requested medication and Mvasi (bevacizumab-awwb) (for example, difference in dyes, fillers, preservatives)? ☐ Yes ☐ No

(if requested medication is Vegzelma) For Zirabev (bevacizumab-bvzr), which of the following applies to your patient?
☐ Patient has not tried this medication.
☐ Patient tried this medication, but it didn't work or didn't work well enough.
☐ Patient tried this medication, but had an allergic or adverse reaction.
☐ Other

(allergic or adverse reaction to Zirabev) Is there documentation that this reaction was due to a formulation difference in the inactive ingredients between the requested medication and Zirabev (bevacizumab-bvzr) (for example, difference in dyes, fillers, preservatives)? ☐ Yes ☐ No

(if documentation that reaction due to formulation difference with Mvasi and Zirabev) Please provide details to support.

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:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

v071525

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