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

Alymsys (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:		* Patient Name:		
Office Contact Person:			* Cigna ID:	* Date of Birth:	
Office Phone:			* Patient Street Address:		
Office Fax:			City:	State:	Zip:
Office Street Address:			Patient Phone:		
City:	State:	Zip:			

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: ☐ Avastin ☐ Alymsys
Is this a new start? ☐ Yes ☐ No Start date:
Dose: Frequency of therapy: Duration of therapy:
Will this medication be given concurrently with other agents? ☐ Yes ☐ No If yes, please specify:
What is your patient's current weight? ICD10:

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

***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 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

Diagnosis:
☐ AIDS-related Kaposi sarcoma (KS)
☐ Ampullary adenocarcinoma
☐ angiosarcoma
☐ cervical cancer (carcinoma of the cervix)
☐ colon or rectal cancer (colorectal cancer, CRC)
☐ non-small cell lung cancer (NSCLC)
☐ endometrial cancer
☐ epithelial ovarian cancer (including serous, mucinous, endometrioid, clear-cell, Brenner or transitional cell)
☐ hepatocellular carcinoma (HCC)
☐ small bowel adenocarcinoma
☐ other (please specify):
☐ fallopian tube cancer
☐ granulosa cell ovarian cancer
☐ CNS/brain tumor
☐ pleural mesothelioma
☐ primary peritoneal cancer
☐ radiation necrosis and uncontrolled cerebral edema
☐ renal cell cancer (RCC)
☐ solitary fibrous tumor/hemangiopericytoma
☐ vulvar squamous cell carcinoma

(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, 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 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)
☐ 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 performance status?
☐ PS 0-2
☐ PS 3-4
☐ unknown

(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 Intron-A? Yes ☐ No ☐

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

(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
- ☐ Unknown

(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
☐ unknown or 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)
☐ unknown

(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 (Adrucil, 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 (Adrucil, 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 this a new start or continuation of therapy with the requested drug? ☐ new start ☐ continuation of therapy

(If new start) 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 new start) 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) 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 yes) Please provide details to support

(If new start) 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

(If allergic or adverse reaction) 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 yes) Please provide details to support.

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:**_____

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.

v021524

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