Avastin, Mvasi, Zirabev

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical*	❑ *Home*	❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital*	❑ *Office*	❑ *Pharmacy*

Exception Criteria Questions:

A. What drug is being prescribed?
- ❑ Mvasi, *Skip to Clinical Criteria Questions*
- ❑ Zirabev, *Skip to Clinical Criteria Questions*
- ❑ Avastin

B. Is the requested medication being prescribed for an ocular indication?
If Yes, Skip to Clinical Criteria Questions ❑ Yes ❑ No

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C. *The preferred products for your patient's health plan are Mvasi and Zirabev.*
Can the patient's treatment be switched to any of the preferred products?
❑ Yes – Mvasi, *Skip to Clinical Criteria Questions*
❑ Yes – Zirabev, *Skip to Clinical Criteria Questions*
❑ No

C. Has the patient failed treatment with both of the preferred products due to a documented intolerable adverse event?
Action Required: If 'Yes', Attach supporting chart note(s). ❑ Yes ❑ No

D. Was the intolerable adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the reference product and biosimilar medication)?
Action Required: If 'No', Attach supporting chart note(s). ❑ Yes ❑ No

Clinical Criteria Questions:

1. What is the prescribed drug? ❑ Avastin ❑ Mvasi ❑ Zirabev

2. What is the diagnosis? *List continues on following page.*
❑ Diabetic macular edema
❑ Neovascular (wet) Age-Related Macular Degeneration
❑ Macular edema due to retinal vein occlusion (RVO)
❑ Proliferative diabetic retinopathy
❑ Choroidal neovascularization (CNV) (including myopic choroidal neovascularization, angioid streaks, choroiditis [including choroiditis secondary to ocular histoplasmosis], idiopathic degenerative myopia, retinal dystrophies, rubeosis iridis, pseudoxanthoma elasticum, and trauma)
❑ Neovascular glaucoma
❑ Retinopathy of prematurity
❑ Polypoidal choroidal vasculopathy
❑ Colorectal cancer (including, appendiceal carcinoma, and anal adenocarcinoma)
❑ Non-squamous non-small cell lung cancer (NSCLC)
❑ Glioblastoma
❑ Intracranial and spinal ependymoma (excludes subependymoma)
❑ Anaplastic glioma
❑ Low-grade (WHO Grade II) infiltrative supratentorial astrocytoma/oligodendroglioma
❑ Medulloblastoma
❑ Primary central nervous system lymphoma
❑ Meningiomas
❑ Limited and extensive brain metastases
❑ Metastatic spine tumors
❑ Epithelial ovarian cancer (including carcinosarcoma [malignant mixed Müllerian tumors], clear cell carcinoma, mucinous carcinoma, grade 1 endometrioid carcinoma, low-grade serous carcinoma, borderline epithelial tumors [low malignant potential] with invasive implants, and malignant sex cord-stromal tumors)
❑ Fallopian tube cancer
❑ Primary peritoneal cancer
❑ Uterine neoplasms
❑ Endometrial carcinoma
❑ Cervical cancer
❑ Vaginal cancer
❑ Breast cancer
❑ Renal cell carcinoma
❑ Angiosarcoma
❑ Solitary fibrous tumor or hemangiopericytoma
❑ Malignant pleural mesothelioma
❑ Vulvar squamous cell carcinoma
❑ Peritoneal mesothelioma
❑ Pericardial mesothelioma

- ❑ Tunica vaginalis testis mesothelioma
- ❑ Hepatocellular carcinoma
- ❑ Small bowel adenocarcinoma
- ❑ Other _____

3. What is the ICD-10 code? _____

4. Is this request for continuation of therapy with the requested medication? ❑ Yes ❑ No *If No, skip to #7*

5. *For ophthalmic disorders,* has the patient demonstrated a positive clinical response to therapy (e.g., improvement or maintenance in best corrected visual acuity [BCVA] or visual field, or a reduction in the rate of vision decline or the risk of more severe vision loss)? ❑ Yes ❑ No

6. *For all other indications,* has the patient experienced a clinical benefit or not experienced an unacceptable toxicity with the requested medication?
   - ❑ Has experienced a clinical benefit
   - ❑ Has not experienced an unacceptable toxicity
   - ❑ None of the above

7. What is the patient's disease type?
   - ❑ Advanced disease ❑ Metastatic disease ❑ Persistent disease ❑ Progressive disease
   - ❑ Recurrent disease ❑ Relapsed disease ❑ Unresectable locally advanced disease
   - ❑ Stage IV disease
   - ❑ Other _____

8. How will the requested medication be given?
   - ❑ Single agent therapy
   - ❑ In combination with temozolomide
   - ❑ In combination with atezolizumab
   - ❑ In combination with pemetrexed and either cisplatin or carboplatin followed by single agent maintenance therapy

Step Therapy Override: Complete if Applicable for the state of Maryland.	Please Circle	
Is the requested drug being used to treat stage four advanced metastatic cancer?	Yes	No
Is the requested drug's use consistent with the FDA-approved indication or the National Comprehensive Cancer Network Drugs & Biologics Compendium indication for the treatment of stage four advanced metastatic cancer and is supported by peer-reviewed medical literature?	Yes	No
Is the requested drug being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?	Yes	No
Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?	Yes	No
Do patient chart notes document the requested drug was ordered with a paid claim at the pharmacy, the pharmacy filled the prescription and delivered to the patient or other documentation that the requested drug was prescribed for the patient in the last 180 days?	Yes	No
Has the prescriber provided proof documented in the patient chart notes that in their opinion the requested drug is effective for the patient's condition?	Yes	No

Step Therapy Override: Complete if Applicable for the state of Virginia.	Please Circle	
Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)?	Yes	No
Does the prescribed dose and quantity fall within the FDA-approved labeling or within dosing guidelines found in the compendia of current literature?	Yes	No
Is the request for a brand drug that has an AB-rated generic equivalent or interchangeable biological product available?	Yes	No
Has the patient had a trial and failure of the AB-rated generic equivalent or interchangeable biological product due to an adverse event (examples: rash, nausea, vomiting, anaphylaxis) that is thought to be due to an inactive ingredient?	Yes	No
Is the preferred drug contraindicated?	Yes	No
Is the preferred drug expected to be ineffective based on the known clinical characteristics of the patient and the prescription drug regimen?	Yes	No
Has the patient tried the preferred drug while on their current or previous health benefit plan and it was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?	Yes	No
Is the patient currently receiving a positive therapeutic outcome with the requested drug for their medical condition?	Yes	No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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