



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

Visit go.covermymeds.com/OptumRx to begin using this free service.

Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Avastin® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

| Member Information <small>(required)</small> | | | Provider Information <small>(required)</small> | | |
|--|--------|------|--|--------|--------------|
| Member Name: | | | Provider Name: | | |
| Insurance ID#: | | | NPI#: | | Specialty: |
| Date of Birth: | | | Office Phone: | | |
| Street Address: | | | Office Fax: | | |
| City: | State: | Zip: | Office Street Address: | | |
| Phone: | | | City: | State: | Zip: |
| Medication Information <small>(required)</small> | | | | | |
| Medication Name: | | | Strength: | | Dosage Form: |
| <input type="checkbox"/> Check if requesting brand | | | Directions for Use: | | |
| <input type="checkbox"/> Check if request is for continuation of therapy | | | | | |
| Clinical Information <small>(required)</small> | | | | | |
| Select the diagnosis below: <input type="checkbox"/> Age-related macular degeneration <input type="checkbox"/> Breast cancer <input type="checkbox"/> Cervical cancer <input type="checkbox"/> Colorectal cancer <input type="checkbox"/> Glioblastoma <input type="checkbox"/> Macular edema following retinal vein occlusion <input type="checkbox"/> Non-small cell lung cancer (NSCLC) <input type="checkbox"/> Renal cell carcinoma (RCC) <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____ | | | | | |
| Continuation of Therapy: Is this request for continuation of prior therapy from within the past 120 days? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| For age-related macular degeneration, answer the following: Is Avastin prescribed or in consultation with an ophthalmologist? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| For breast cancer, answer the following: Will Avastin be used in combination with paclitaxel? <input type="checkbox"/> Yes <input type="checkbox"/> No Is Avastin prescribed by or in consultation with a hematologist or oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| For cervical cancer, answer the following: Does the patient have persistent, recurrent, or metastatic carcinoma of the cervix? <input type="checkbox"/> Yes <input type="checkbox"/> No Select if Avastin will be used in combination with one of the following: <input type="checkbox"/> Paclitaxel and cisplatin <input type="checkbox"/> Paclitaxel and topotecan Is Avastin prescribed by or in consultation with a hematologist, oncologist, or gynecologic oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| For colorectal cancer, answer the following: Does the patient have metastatic disease? <input type="checkbox"/> Yes <input type="checkbox"/> No Select if Avastin will be used in combination with one of the following: <input type="checkbox"/> 5-fluorouracil (5-FU) <input type="checkbox"/> Oxaliplatin <input type="checkbox"/> Capecitabine <input type="checkbox"/> CapeOX (capecitabine and oxaliplatin) <input type="checkbox"/> Irinotecan <input type="checkbox"/> 5-FU/LV (fluorouracil and leucovorin) <input type="checkbox"/> Fluoropyrimidine (e.g., capecitabine, floxuridine, fluorouracil)- irinotecan -based therapy <input type="checkbox"/> Fluoropyrimidine (e.g., capecitabine, floxuridine, fluorouracil)- oxaliplatin -based therapy Is Avastin prescribed by or in consultation with a hematologist or oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: Avastin_CMS_2019Jan-W



Avastin[®] Prior Authorization Request Form (Page 2 of 2)
DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

For glioblastoma, answer the following:

Does the patient have recurrent disease? Yes No

Is Avastin prescribed by or in consultation with a hematologist or oncologist? Yes No

For macular edema following retinal vein occlusion, answer the following:

Is Avastin prescribed or in consultation with an ophthalmologist? Yes No

For non-small cell lung cancer (NSCLC), answer the following:

Does the patient have unresectable, locally advanced, recurrent, or metastatic disease? Yes No

Select if Avastin be used in combination with the following:

Carboplatin

Paclitaxel

Does the patient have a performance status that is 0 to 1? Yes No

Does the patient have squamous cell histology? Yes No

Does the patient have history of hemoptysis? Yes No

Is Avastin prescribed by or in consultation with a hematologist or oncologist? Yes No

For renal cell carcinoma (RCC), answer the following:

Does the patient have metastatic disease? Yes No

Will Avastin be used in combination with interferon-alfa? Yes No

Is Avastin prescribed by or in consultation with a hematologist or oncologist? Yes No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note:

This request may be denied unless all required information is received.

If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.

For urgent or expedited requests please call 1-800-711-4555.

This form may be used for non-urgent requests and faxed to 1-800-527-0531.