P.O. Box 30192
Salt Lake City, UT 84130-0192
801-442-4912 or 800-442-3129
Fax 801-442-3006

selecthealth℠

# PREAUTHORIZATION FORM
Avastin®
(bevacizumab)

**Therapeutic use:** Avastin is a monoclonal antibody which binds to vascular endothelial growth factor (VEGF) and is approved for treatment of multiple cancer types

**Quantity Limit:**

- Colorectal: 12 doses per 180 days (10 mg/kg IV infusion every 14 days)
- NSCLC: 9 doses per 180 days (15 mg/kg IV infusion every 21 days)
- Glioblastoma: 12 doses per 180 days (10mg/kg IV infusion every 14 days)
- RCC: 12 doses per 180 days (10mg/kg IV infusion every 14 days)

**Authorization Period:** 12 months

Patient's name _____

Patient's ID# ☐☐☐ ☐☐ ☐☐☐☐ DOB ☐☐/☐☐/☐☐☐☐

ICD-9 ☐☐☐ ☐☐ ☐☐☐ ☐☐ _____

Physician's name_____

Physician's Ph# (☐☐☐) ☐☐☐-☐☐☐☐ Fax# ☐☐☐-☐☐☐☐

Physician's signature_____ Date signed ☐☐/☐☐/☐☐☐☐

Supervising Physician's name_____ (Required if requesting provider is a nurse practitioner or physician assistant)

| Please check "Yes" or "No" and respond to the following requests: | | | |
|---|---|---|---|
| 1. | Does the patient have metastatic cancer of the colon or rectum? | ❑ Yes | ❑ No |
| 1a. | Is Avastin being used in combination with 5-Flurouracil or capecitabine? | ❑ Yes | ❑ No |
| 2. | Does the patient have NSCLC? | ❑ Yes | ❑ No |
| 2a. | Is Avastin being used in combination with carboplatin/paclitaxel (CP) or erlotinib? | ❑ Yes | ❑ No |
| 3. | Does the patient have glioblastoma multiforme of the brain? | ❑ Yes | ❑ No |
| 3a. | Has the patient shown resistance or intolerance to prior therapy with temozolomide? | ❑ Yes | ❑ No |
| 4. | Does the patient have metastatic renal cell carcinoma (mRCC)? | ❑ Yes | ❑ No |
| 4a. | Is Avastin being used in combination with interferon alpha? | ❑ Yes | ❑ No |
| Important Note: Avastin should not be used until 28 days have elapsed since the patients last surgery and there is complete healing of the incision.<br>Avastin for ocular use should be billed under C9257; this code does not require preauthorization. | | | |

**This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.**

**Preauthorization Internal Documentation**

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