

**Blue Cross and Blue Shield of Vermont and The Vermont Health Plan  
Prior Approval Form  
Avastin™(bevacizumab)  
BCBSVT and TVHP Fax # (888)–255-1006**

Date of Request \_\_\_\_\_ Patient Name: \_\_\_\_\_  
 Member ID#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Provider Name: \_\_\_\_\_ Provider Phone: \_\_\_\_\_  
 Provider Fax: \_\_\_\_\_ PCP Name: \_\_\_\_\_  
 Patient Weight: \_\_\_\_\_

**FOR Oncology USE**

	YES	NO
1. Does patient have metastatic carcinoma of the colon or rectum?	<input type="checkbox"/>	<input type="checkbox"/>
2. If being used for Metastatic Carcinoma of the colon or rectum will Avastin be used in combination with 5-fluorouracil?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does patient have a diagnosis of Non-squamous Non-Small Cell Lung Cancer?	<input type="checkbox"/>	<input type="checkbox"/>
4. If Avastin is being used for Non Squamous Non Small Cell Lung Cancer will Avastin be used in combination with carboplatin and paclitaxel?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the patient have Metastatic Breast Cancer or malignant glioma?	<input type="checkbox"/>	<input type="checkbox"/>
6. Avastin in combination with interferon-alfa, for the treatment of metastatic renal cell carcinoma?	<input type="checkbox"/>	<input type="checkbox"/>
7. If Avastin is being used for Breast Cancer will Avastin be used as monotherapy?	<input type="checkbox"/>	<input type="checkbox"/>
8. Does patient have a history of gastric perforation?	<input type="checkbox"/>	<input type="checkbox"/>
9. Does patient have a history of gastric surgery?	<input type="checkbox"/>	<input type="checkbox"/>
10. Does patient have a history of recent hemoptysis?	<input type="checkbox"/>	<input type="checkbox"/>
11. Will Prescription be dispensed at (circle one): <b>Provider Office</b> <b>Network Pharmacy</b>		

**For Ophthalmology Use**

	YES	NO
12. Does patient have Neovascular (Wet) Age Related Macular Degeneration?	<input type="checkbox"/>	<input type="checkbox"/>
13. Will bevacizumab be administered intravitreally monthly at a dose of 1.25mg?	<input type="checkbox"/>	<input type="checkbox"/>
14. Does the patient have ocular or periocular infection?	<input type="checkbox"/>	<input type="checkbox"/>
15. Does the patient have uncontrolled hypertension?	<input type="checkbox"/>	<input type="checkbox"/>
16. Has the patient received previous treatment with photodynamic therapy or Macugen®? Please provide clinician office visit note documenting treatment failure.	<input type="checkbox"/>	<input type="checkbox"/>

**If this is a renewal Please complete the questions below**

17. The patient has demonstrated the following: a) Improvement in visual acuity (VA) b) Decrease in central macular thickness c) Decrease in central retinal thickness d) Decrease or resolution of subretinal fluid/macular edema Please submit clinician office note with documented progress including baseline VA, duration of improvement and the patients' current symptoms if any.	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18. Provide the date of the last injection:		

**Initial approval for 3 month period; Renewal approval period 6 months**

PRESCRIBER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**By signing above, the prescriber confirms all information provided is accurate and verifiable via member records.**