

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

If approval criteria are met, coverage of Avastin™ (bevacizumab) will be authorized Thank you for your assistance.

PLEASE COMPLETE THE FOLLOWING SECTIONS:

Date of Request _____ Patient Name: _____
 Member ID#: _____ Date of Birth: _____
 Provider Name: _____ Provider Phone: _____
 Provider Fax: _____ PCP Name: _____

INDICATIONS FOR USE	<u>YES</u>	<u>NO</u>
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 patient have a history of gastric perforation?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does patient have a history of gastric surgery?	<input type="checkbox"/>	<input type="checkbox"/>
7. Does patient have a history of recent hemoptysis?	<input type="checkbox"/>	<input type="checkbox"/>
8. Will Prescription be dispensed at (circle one): Provider Office RESTAT Pharmacy		

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

Dose: _____ Frequency: _____ Duration of Therapy: _____

PRESCRIBER SIGNATURE _____ DATE _____

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

