Avastin, Alymsys, Mvasi, Vegzelma, 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 is the ICD-10 code? _____

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

C. Is the product being requested for the treatment of an oncology indication?
- ❑ Yes ❑ No *If No, skip to Clinical Criteria Questions*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

 Alymsys, Avastin, Mvasi, Vegzelma, Zirabev MR SGM 1891-A – 08/2023.

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com

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

E. Does the patient have a documented intolerable adverse event to all of the preferred products (Alymsys, Mvasi, and Zirabev) that was NOT 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 products)?
ACTION REQUIRED: If 'Yes', Attach supporting chart note(s). ❑ Yes ❑ No

Clinical Criteria Questions:

1. What is the diagnosis?

❒ Diabetic macular edema (*If checked, go to 25*)
❒ Neovascular (wet) Age-Related Macular Degeneration (*If checked, go to 25*)
❒ Macular edema due to retinal vein occlusion (RVO) (*If checked, go to 25*)
❒ Proliferative diabetic retinopathy (*If checked, go to 25)*
❒ 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) (*If checked, go to 25*)
❒ Neovascular glaucoma (*If checked, go to 25*)
❒ Retinopathy of prematurity (*If checked, go to 25*)
❒ Polypoidal choroidal vasculopathy (*If checked, go to 25*)
❒ Colorectal cancer, including appendiceal adenocarcinoma and anal adenocarcinoma (*If checked, go to* 2)
❒ Non-squamous non-small cell lung cancer (NSCLC) (*If checked, go to 2*)
❒ Glioma (WHO Grade 1) (*If checked, go to 2*)
❒ Diffuse high grade gliomas (*If checked, go to 2*)
❒ Glioblastoma (*If checked, go to 2*)
❒ IDH mutant astrocytoma (WHO Grade 2, 3 or 4) (*If checked, go to 2*)
❒ Oligodendroglioma (WHO Grade 2 or 3) (*If checked, go to 2*)
❒ Intracranial and spinal ependymoma (excludes subependymoma) (*If checked, go to 2*)
❒ Medulloblastoma (*If checked, go to 2*)
❒ Primary central nervous system lymphoma (*If checked, go to 2*)
❒ Meningiomas (*If checked, go to 2*)
❒ Limited and extensive brain metastases (*If checked, go to 2*)
❒ Metastatic spine tumors (*If checked, go to 2*)
❒ Epithelial ovarian cancer (*If checked, go to 2*)
❒ Fallopian tube cancer (*If checked, go to 2*)
❒ Primary peritoneal cancer (*If checked, go to 2*)
❒ Malignant sex cord stromal tumors (*If checked, go to 2*)
❒ Uterine neoplasms (*If checked, go to 2*)
❒ Endometrial carcinoma (*If checked, go to 2*)
❒ Cervical cancer (*If checked, go to 2*)
❒ Vaginal cancer (*If checked, go to 2*)

❒ Breast cancer (*If checked, go to 2*)

❒ Renal cell carcinoma (*If checked, go to 2*)

❒ Angiosarcoma (*If checked, go to 2*)

❒ Solitary fibrous tumor or hemangiopericytoma (*If checked, go to 2*)

❒ Mesothelioma (malignant pleural, malignant peritoneal, pericardial, or tunica vaginalis testis) (*If checked, go to 2*)

❒ Vulvar carcinoma, including squamous cell carcinoma and adenocarcinoma (*If checked, go to 2*)

❒ Hepatocellular carcinoma (*If checked, go to 2*)

❒ Small bowel adenocarcinoma (*If checked, go to 2*)

❒ Ampullary Adenocarcinoma (*If checked, go to 2*)

❒ Other, please specify. _____ (*If checked, no further questions*)

2. Is this request for continuation of therapy with the requested medication?

❒ Yes, *Continue to 3*

❒ No, *Continue to 4*

3. Has the patient experienced an unacceptable toxicity or disease progression while on the current regimen?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

4. What is the diagnosis?

❒ Colorectal cancer, including appendiceal adenocarcinoma and anal adenocarcinoma (*If checked, no further questions*)

❒ Non-squamous non-small cell lung cancer (NSCLC) (*If checked, go to 5*)

❒ Glioma (WHO Grade 1) (*If checked, no further questions*)

❒ Diffuse high grade gliomas (*If checked, no further questions*)

❒ Glioblastoma (*If checked, no further questions*)

❒ IDH mutant astrocytoma (WHO Grade 2, 3 or 4) (*If checked, no further questions*)

❒ Oligodendroglioma (WHO Grade 2 or 3) (*If checked, no further questions*)

❒ Intracranial and spinal ependymoma (excludes subependymoma) (*If checked, no further questions*)

❒ Medulloblastoma (*If checked, no further questions*)

❒ Primary central nervous system lymphoma (*If checked, no further questions*)

❒ Meningiomas (*If checked, no further questions*)

❒ Limited and extensive brain metastases (*If checked, no further questions*)

❒ Metastatic spine tumors (*If checked, no further questions*)

❒ Epithelial ovarian cancer (*If checked, no further questions*)

❒ Fallopian tube cancer (*If checked, no further questions*)

❒ Primary peritoneal cancer (*If checked, no further questions*)

❒ Malignant sex cord stromal tumors (*If checked, no further questions*)

❒ Uterine neoplasms (*If checked, go to 6*)

❒ Endometrial carcinoma (*If checked, go to 6*)

❒ Cervical cancer (*If checked, go to 7*)

❒ Vaginal cancer (*If checked, go to 7*)

❒ Breast cancer (*If checked, go to 8*)

❒ Renal cell carcinoma (*If checked, go to 9*)

❒ Angiosarcoma (*If checked, go to 10*)

❒ Solitary fibrous tumor or hemangiopericytoma (*If checked, go to 11*)

❒ Mesothelioma (malignant pleural, malignant peritoneal, pericardial, or tunica vaginalis testis) (*If checked, go to 12*)

❒ Vulvar carcinoma, including squamous cell carcinoma and adenocarcinoma (*If checked, go to 19*)

❒ Hepatocellular carcinoma (*If checked, go to 20*)

❒ Small bowel adenocarcinoma (*If checked, no further questions*)

❒ Ampullary Adenocarcinoma (*If checked, go to 23*)

5. Does the patient have recurrent, advanced, metastatic, or unresectable disease?

❒ Recurrent disease (*If checked, no further questions*)

❒ Advanced disease (*If checked, no further questions*)

❒ Metastatic disease (*If checked, no further questions*)

❒ Unresectable disease (*If checked, no further questions*)

❒ None of the above (*If checked, no further questions*)

6. Does the patient have progressive, advanced, recurrent, or metastatic disease?

❒ Progressive disease (*If checked, no further questions*)

❒ Advanced disease (*If checked, no further questions*)

❒ Recurrent disease (*If checked, no further questions*)

❒ Metastatic disease (*If checked, no further questions*)

❒ None of the above (*If checked, no further questions*)

7. Does the patient have persistent, recurrent, or metastatic disease?

❒ Persistent disease (*If checked, no further questions*)

❒ Recurrent disease (*If checked, no further questions*)

❒ Metastatic disease (*If checked, no further questions*)

❒ None of the above (*If checked, no further questions*)

8. Does the patient have recurrent or metastatic disease?

❒ Recurrent disease (*If checked, no further questions*)

❒ Metastatic disease (*If checked, no further questions*)

❒ None of the above (*If checked, no further questions*)

9. Does the patient have relapsed or stage IV disease?

❒ Relapsed disease (*If checked, no further questions*)

❒ Stage IV disease (*If checked, no further questions*)

❒ None of the above (*If checked, no further questions*)

10. Will the requested medication be given as a single agent therapy?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

11. Will the requested medication be given in combination with temozolomide?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

12. What is the place in therapy in which the requested drug will be used?

❒ First-line treatment (*If checked, go to 13*)

❒ Subsequent treatment (*If checked, go to 15*)

13. Will the requested medication be given in combination with pemetrexed (Altimta) and either cisplatin (Platinol) or carboplatin (Paraplatin), followed by single-agent maintenance bevacizumab?

❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. Does the patient have unresectable disease?
❒ Yes, *Continue to 15*
❒ No, *Continue to 15*

15. Will the requested drug be used in any of the following regimens?
❒ In combination with pemetrexed (Alimta) and either cisplatin (Platinol) or carboplatin (Paraplatin) (*If checked, go to 16*)
❒ In combination with atezolizumab (Tecentriq) (*If checked, go to 18*)
❒ No (*If checked, no further questions*)

16. Has the patient received immunotherapy as first-line treatment?
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. Please indicate the type of mesothelioma which applies to the patient's disease.
❒ Malignant pleural mesothelioma (*If checked, no further questions*)
❒ Malignant peritoneal mesothelioma (*If checked, no further questions*)
❒ Pericardial mesothelioma (*If checked, no further questions*)
❒ Tunica vaginalis testis mesothelioma (*If checked, no further questions*)
❒ Other, please specify. _____ (*If checked, no further questions*)

18. Please indicate the type of mesothelioma which applies to the patient's disease.
❒ Malignant pleural mesothelioma (*If checked, no further questions*)
❒ Malignant peritoneal mesothelioma (*If checked, no further questions*)
❒ Pericardial mesothelioma (*If checked, no further questions*)
❒ Tunica vaginalis testis mesothelioma (*If checked, no further questions*)
❒ Other, please specify. _____ (*If checked, no further questions*)

19. Does the patient have unresectable locally advanced, recurrent, or metastatic disease?
❒ Unresectable locally advanced disease (*If checked, no further questions*)
❒ Recurrent disease (*If checked, no further questions*)
❒ Metastatic disease (*If checked, no further questions*)
❒ None of the above (*If checked, no further questions*)

20. Does the patient have unresectable or metastatic disease?
❒ Unresectable disease (*If checked, go to 21*)
❒ Metastatic disease (*If checked, go to 21*)
❒ None of the above (*If checked, go to 21*)

21. Will the requested drug be used as initial treatment?
❒ Yes, *Continue to 22*
❒ No, *Continue to 22*

22. Will the requested medication be given in combination with atezolizumab (Tecentriq)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

23. Please indicate the type of ampullary adenocarcinoma which applies to the patient's disease.
❒ Intestinal-type (*If checked, go to 24*)

❒ Other, please specify. _____ (*If checked, go to 24*)

24. Does the patient have progressive, unresectable, or metastatic disease?

❒ Progressive disease (*If checked, no further questions*)

❒ Unresectable disease (*If checked, no further questions*)

❒ Metastatic disease (*If checked, no further questions*)

❒ None of the above (*If checked, no further questions*)

25. Is this a request for continuation of therapy with the requested medication?
❒ Yes, *Continue to 26*
❒ No, *No Further Questions*

26. 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 Further Questions*
❒ No, *No Further Questions*

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)**

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720