Peach State Health Plan™

Please Reply Promptly

AVASTIN AUTHORIZATION REQUEST

Dear ,:

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 Peachstate toll-free at 866-374-1579. If you have questions regarding the prior authorization, please contact Peachstate toll-free at 800-514-0083 option # 2.

Patient Name:
Patient ID#:
Patient Date of Birth:

Physician Name:
Physician Phone:
Physician Fax:

1. Which drug is being prescribed? ☐ Avastin Dose: ___________ Frequency ___________
2. What is the diagnosis? ☐ Metastatic colorectal cancer ☐ Non-squamous non-small cell lung cancer ☐ Metastatic breast cancer ☐ Glioblastoma ☐ Metastatic renal cell cancer ☐ Other _____________
3. What is the medical specialty of the prescribing physician? ☐ oncologist ☐ other _________________
4. Is the patient an adult? ☐ Yes ☐ No
5. For Metastatic Colorectal Cancer will treatment be in conjunction with intravenous 5-flurouracil-based chemotherapy (bolus-IFL, FOLFOX4)? ☐ Yes ☐ No
6. For Non-Squamous Non-Small Cell Lung cancer will treatment be in conjunction with carboplatin and paclitaxel? ☐ Yes ☐ No
7. For Metastatic Renal Cell Carcinoma will treatment be in conjunction with interferon alfa? ☐ Yes ☐ No
8. For Metastatic Breast Cancer will treatment be in conjunction with paclitaxel? ☐ Yes ☐ No
9. For Glioblastoma will this be used as a single agent? ☐ Yes ☐ No
10. Does the member have a history of any of the following? Please provide evidence.
    - ☐ Gastrointestinal perforation
    - ☐ Hemorrhage or recent hemoptysis
    - ☐ Arterial thromboembolic events
    - ☐ Reversible Posterior Leukoencephalopathy
    - ☐ NONE
    - ☐ Surgery and wound healing complications
    - ☐ Non-gastrointestinal fistula
    - ☐ Hypertension
    - ☐ Proteinuria
11. Please attach chemotherapy treatment regimen.

SECTION A: Recertification/Reauthorization

Only answer if the following questions if the patient is on therapy?

12. Has there been any symptom issues? ☐ Yes ☐ No

    Skip question #13 if the answer is no.

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13. What symptoms or events are being monitor? ______________________________

14. Had Avastin previously been held? ☐ Yes ☐ No

15. Please give reason(s): ____

16. Has the patient remained compliant? ☐ Yes ☐ No

17. Has disease progressed? ☐ Yes ☐ No

18. Will the dose ☐ Continue the same as starting dose ☐ decrease by ____%, ☐ increased by ___%

____

Prescriber or Authorized Signature **Date**

NOTE: We can NOT make a decision without a copy of lab results - Thank You