BlueCross BlueShield Federal Employee Program

Return completed fax to
Blue Shield of California
Fax: 1-855-895-3504

AVASTIN
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form. All incomplete and illegible forms will be returned to the patient.

CARDHOLDER AND PATIENT INFORMATION

Date: ____ / ____ / ____

Cardholder Name: _____ / _____ / _____
First MI Last

Patient Name: _____ / _____ / _____
First MI Last

Patient Address: _____
Street City State Zip

Patient Date of Birth: ____/ ____/ ____ Sex: M ____ F ____ **R** [| | | | | | | | |]
Cardholder Identification Number

PHYSICIAN COMPLETES

NOTE: Form must be completed in its **entirety** for processing

1. What is the patient's diagnosis?

❑ **Metastatic Colorectal Cancer (*please answer questions a-d below*)**
a. Is the patient receiving concurrent IV chemotherapy with 5-Fluorouracil (5-FU)? ❑ **Yes** ❑ **No**
b. Will the patient be receiving Fluropyrimidine iniotecan-based chemotherapy or oxaliplatin-based chemotherapy?
❑ Fluropyrimidine-iniotecan based chemotherapy ❑ Fluropyrimidine-oxaliplatin based chemotherapy
❑ The patient will **NOT** be receiving concurrent therapy ❑ Other ***(please specify):*** _____
c. Is Avastin being used as second-line therapy? ❑ **Yes** ❑ **No**
d. Has the patient progressed on a first-line Avastin containing regimen? ❑ **Yes** ❑ **No**

❑ **Non-Squamous, Non-Small Cell Lung Cancer (*please answer questions a-d below*)**
a. Is the Avastin being used as first-line therapy? ❑ **Yes** ❑ **No**
b. Is the cancer unresectable, locally advanced, recurrent or metastic?
❑ Unresectable ❑ Locally advanced ❑Recurrent ❑ Metastatic ❑Other ***(please specify):*** _____
c. Will the patient be receiving concurrent therapy with carboplatin? ❑ **Yes** ❑ **No**
d. Will the patient be receiving concurrent therapy with paclitaxel? ❑ **Yes** ❑ **No**

❑ **Glioblastoma Multiforme (GBM) *(please answer questions a & b below)***
a. Is Avastin being used as single agent therapy? ❑ **Yes** ❑ **No**
b. Is there progressive disease following prior therapy? ❑ **Yes** ❑ **No**

❑ **Metastatic Renal Cell Carcinoma (*please answer the following question below*)**
a. Is the patient receiving concurrent therapy with interferon-alfa? ❑ **Yes** ❑ **No**

❑ **Ocular Disease (*please check appropriate diagnosis)*:**
❑ Diabetic Macular Edema ❑ Retinopathy of prematurity ❑ Ocular histoplasmosis
❑ Progressive high myopia ❑ Proliferative diabetic retinopathy ❑ Angioid streaks
❑ Neovascular glaucoma ❑ Neovascular (Wet) Age-Related Macular Degeneration (AMD)
❑ Macular edema secondary to retinal vascular occlusion

❑ **Persistent, Recurrent, or Metastatic Cervical Cancer *(please answer questions a & b below)***
a. Is the patient receiving concurrent therapy with paclitaxel and cisplatin? ❑ **Yes** ❑ **No**
b. Is the patient receiving concurrent therapy with paclitaxel and topotecan? ❑ **Yes** ❑ **No**

❑ **Ovarian Cancer Please specify type: ❑Epithelial ❑Fallopian Tube ❑Primary Peritoneal**
a. Is the cancer Platinum-**resistant**? ❑ **Yes** ❑ **No**
b. Is the cancer recurrent? ❑ **Yes** ❑ **No**
c. Is the patient receiving concurrent therapy with: ❑paclitaxel ❑pegylated liposomal doxorubin ❑topotecan ❑Other _____

❑ **Other diagnosis (*please specify*):** _____

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer.

_____ (_____) _____ (_____) _____
Physician Name (Print Clearly) Phone Fax

_____ _____ _____ _____
Street Address City State Zip

_____ _____ _____/ _____/ _____
Prescriber's NPI Physician Signature Date