



Metastatic

Other \_\_\_\_\_

**Initial Authorization for NSCLC:**

- Avastin® will be used as first line therapy
- Individual with performance status 0 -1
- Individual with no history of hemoptysis
- Individual will receive Avastin® with platinum-based therapy
  - Will receive in combination with a taxane
  - Will receive in combination with pemetrexed (Alimta®)
- Individual will not be receiving other targeted biologic agents at the same time
- Other \_\_\_\_\_

**Reauthorization only for NSCLC:**

- Avastin® to be used as maintenance therapy
- Avastin® was used as an agent in first-line combination regimen
- Avastin® to be used as a single agent
- There has been no disease progression since this treatment regimen started
- Individual will not be receiving other targeted biologic agents at the same time
- Other \_\_\_\_\_

**(3) Metastatic Breast Carcinoma**

- Individual has been diagnosed with metastatic breast carcinoma
- This will be used for first line chemotherapy (**Note:** Hormonal therapy alone is not considered “chemotherapy”)
- Individual has been diagnosed with HER2-negative breast cancer
- Individual will receive Avastin® in combination with paclitaxel
- Individual will receive Avastin® in combination with paclitaxel protein-bound
- Individual will not be receiving other targeted biologic agents at the same time
- Other \_\_\_\_\_

**(4) Primary Central Nervous System Tumor**

- Individual has been diagnosed with a primary central nervous system tumor. **If checked**, please check the following that apply
  - Anaplastic astrocytoma
  - Progressive or recurrent ependymoma that has failed radiation therapy
  - Anaplastic glioma
  - Recurrent, high-grade glioma
  - Glioblastoma multiforme who have failed radiation therapy
- Avastin® has not been used in previous line of therapy
- Individual will not be receiving other targeted biologic agents at the same time
- Other \_\_\_\_\_

**(5) Metastatic Epithelial Ovarian Cancer / Fallopian Tube Cancer / Primary Peritoneal Cancer**

- Individual has been diagnosed with recurrent, metastatic epithelial ovarian cancer
- Individual has been diagnosed with fallopian tube cancer
- Individual has been diagnosed with recurrent, primary peritoneal cancer
- Avastin® will be used as a single agent
- This is to be used as a 3<sup>rd</sup> line of therapy or later
- Individual will not be receiving other targeted biologic agents at the same time
- Other \_\_\_\_\_

**(6) Metastatic Clear Cell Renal Cell Carcinoma (RCC)**

- Individual has been diagnosed with metastatic clear cell renal carcinoma
- Individual will receive Avastin® in combination with interferon as first line treatment
- Individual will not be receiving other targeted biologic agents at the same time
- Other \_\_\_\_\_

**(7) Angiosarcoma**

- Individual has been diagnosed with angiosarcoma
- Avastin® will be used as a single agent
- Individual will not be receiving other targeted biologic agents at the same time
- Other \_\_\_\_\_

**(8) Solitary Fibrous Tumor / Hemangiopericytoma**

- Individual has been diagnosed with a solitary fibrous tumor
- Individual has been diagnosed with hemangiopericytoma
- Individual will receive Avastin® in combination with temozolomide
- Individual will not be receiving other targeted biologic agents at the same time
- Other \_\_\_\_\_

**(9) Other Use(s)** (Please submit all supporting documents including labs, progress notes, imaging, etc., for review.)

**Anthem UM Services, Inc., a separate company, is the licensed utilization review agent that performs utilization management services on behalf of your health benefit plan or the administrator of your health benefit plan.**

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This request is being submitted:

Pre-Claim

Post-Claim. If checked, please attach the claim or indicate the claim number \_\_\_\_\_

I attest the information provided is true and accurate to the best of my knowledge. I understand that the health plan or its designees may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

\_\_\_\_\_  
Name & Title of Provider or Provider Representative Completing Form  
& attestation (Please Print)\*

/ /  
Date

**\*The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted**

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