JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Avastin, Mvasi, Zirabev

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756** to initiate the review process. If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

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*

Drug Information:

*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_____ *Route of administration*_____
*Dosing frequency*_____

Send completed form to: Priority Partners Fax: 1-866-212-4756

Criteria Questions:

1. What is the prescribed drug? ❑ Avastin ❑ Mvasi ❑ Zirabev

2. What is the diagnosis? *List continues on following page.*
   - ❑ Diabetic macular edema
   - ❑ Neovascular (wet) Age-Related Macular Degeneration
   - ❑ Macular edema due to retinal vein occlusion (RVO)
   - ❑ Proliferative diabetic retinopathy
   - ❑ 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)
   - ❑ Neovascular glaucoma
   - ❑ Retinopathy of prematurity
   - ❑ Polypoidal choroidal vasculopathy
   - ❑ Colorectal cancer (including, appendiceal carcinoma, and anal adenocarcinoma)
   - ❑ Non-squamous non-small cell lung cancer (NSCLC)
   - ❑ Glioblastoma
   - ❑ Intracranial and spinal ependymoma (excludes subependymoma)
   - ❑ Anaplastic glioma
   - ❑ Low-grade (WHO Grade II) infiltrative supratentorial astrocytoma/oligodendroglioma
   - ❑ Medulloblastoma
   - ❑ Primary central nervous system lymphoma
   - ❑ Meningiomas
   - ❑ Limited and extensive brain metastases
   - ❑ Metastatic spine tumors
   - ❑ Epithelial ovarian cancer (including carcinosarcoma [malignant mixed Müllerian tumors], clear cell carcinoma, mucinous carcinoma, grade 1 endometrioid carcinoma, low-grade serous carcinoma, borderline epithelial tumors [low malignant potential] with invasive implants, and malignant sex cord-stromal tumors)
   - ❑ Fallopian tube cancer
   - ❑ Primary peritoneal cancer
   - ❑ Uterine neoplasms
   - ❑ Endometrial carcinoma
   - ❑ Cervical cancer
   - ❑ Vaginal cancer
   - ❑ Breast cancer
   - ❑ Renal cell carcinoma
   - ❑ Angiosarcoma
   - ❑ Solitary fibrous tumor or hemangiopericytoma
   - ❑ Malignant pleural mesothelioma
   - ❑ Vulvar squamous cell carcinoma
   - ❑ Peritoneal mesothelioma
   - ❑ Pericardial mesothelioma
   - ❑ Tunica vaginalis testis mesothelioma
   - ❑ Hepatocellular carcinoma
   - ❑ Small bowel adenocarcinoma
   - ❑ Other _____

3. What is the ICD-10 code? _____

4. Is this request for continuation of therapy with the requested medication? ❑ Yes ❑ No *If No, skip to #7*

5. *For ophthalmic disorders,* 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

6. *For all other indications*, has the patient experienced a clinical benefit or not experienced an unacceptable toxicity with the requested medication?
   - ❑ Has experienced a clinical benefit
   - ❑ Has not experienced an unacceptable toxicity
   - ❑ None of the above

7. What is the patient's disease type?
   - ❑ Advanced disease
   - ❑ Metastatic disease
   - ❑ Persistent disease
   - ❑ Progressive disease
   - ❑ Recurrent disease
   - ❑ Relapsed disease
   - ❑ Unresectable locally advanced disease
   - ❑ Stage IV disease
   - ❑ Other _____

8. How will the requested medication be given?
   - ❑ Single agent therapy
   - ❑ In combination with temozolomide
   - ❑ In combination with atezolizumab
   - ❑ In combination with pemetrexed and either cisplatin or carboplatin followed by single agent maintenance therapy

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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