



**Alymsys, Avastin, Mvasi, Vegzelma, Zirabev
HMSA COM - 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 1-866-237-5512.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414**. 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:** _____
Patient's Phone Number: _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Patient Weight: _____ kg
Patient Height: _____ ft _____ inches

Indicate where the drug is being dispensed:

- Office Outpatient Hospital Ambulatory Surgical Inpatient Hospital
- Off Campus Outpatient Hospital Urgent Care Emergency Room Birthing Center
- Military Facility Skilled Nursing Facility Nursing Facility Hospice
- Inpatient Psychiatric Psychiatric Residential Treatment End Stage Renal Facility
- Psychiatric Facility Pharmacy Other

Indicate where the drug is being administered:

- Ambulatory surgical Home Inpatient Hospital
- Office Outpatient Hospital Pharmacy

Exception Criteria Questions:

- A. Is the requested drug being used for an oncology diagnosis? Yes No *If No, no further questions*
- B. What product is being requested?
- Alymsys
 - Avastin
 - Vegzelma
 - Mvasi, *Skip to Criteria Questions*
 - Zirabev, *Skip to Criteria Questions*

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Bevacizumab biosimilars HMSACOM MR – 01/2024.

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- C. The preferred products for your patient's health plan are Mvasi and Zirabev. Can the patient's treatment be switched to a preferred product?
 Yes, Mvasi *Skip to Criteria Questions*
 Yes, Zirabev, *Skip to Criteria Questions*
 No
- D. Does the patient have a documented intolerable adverse event to treatment with both of the preferred products, Mvasi and Zirabev? ***ACTION REQUIRED: If 'Yes', attach supporting chart notes(s).*** Yes No
- E. Was the documented intolerable adverse event 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 'No', attach supporting chart note(s).*** Yes No

Criteria Questions:

1. Please list or describe all agents in the oncology regimen. Single agent Multiple agents

2. What is the patient's diagnosis and ICD 10 code? **Action Required: Please attach relevant and supportive data of patient's diagnosis.**

5. Is the requested medication/regimen prescribed for an FDA-approved indication, an indication supported by NCCN with a I or IIA recommendation? Yes No
6. Does the patient have a contraindication to the use of the requested medication(s) as listed in the medication(s) prescribing information? Yes No
7. Was the single agent or entire drug regimen previously authorized by HMSA/CVS for this member?
 Yes No Unknown *If No or unknown, no further questions*
8. Is there evidence to support the patient is benefitting from treatment (e.g. positive clinical response, lack of disease progression)? **Action required: Please attach current clinical documentation (e.g., office visit notes and applicable studies) that supports treatment is beneficial.** Yes No *No further questions*

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)

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