

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
AVASTIN (bevacizumab)

Patient name: _____ Medicaid ID #: _____

Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____

Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____

Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____

Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY TO 855-828-4992**

CRITERIA:

- Minimum age - 18 years old.
- Documentation of one of the following diagnoses:
 - metastatic colorectal cancer
 - non-squamous non-small cell lung cancer
 - glioblastoma
 - metastatic renal cell carcinoma
 - persistent, recurrent or metastatic carcinoma of the cervix
 - platinum-resistant recurrent epithelial ovarian, fallopian tube or primary peritoneal cancer

NOTE: Avastin is no longer FDA-approved for the treatment of breast cancer, and prior authorization requests will not be approved.

INFORMATION:

To be given in clinic setting only. Provider will bill with J code J9035, NDC number, and PA number. Patients with ACOs must make arrangements with their ACO for coverage.

AUTHORIZATION:

Initial prior is for 1 year

RE-AUTHORIZATION:

Subsequent PA is for 1 year, with an updated letter of medical necessity.

08/31/2015

<https://medicaid.utah.gov/pharmacy/>