

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 note the new fax number

CRITERIA:

- Minimum age - 18 years old.
- Documentation of diagnosis of metastatic carcinoma of colon or rectum or non-squamous, non-small cell lung cancer; OR
- Glioblastoma with progressive disease following prior therapy; OR
- Metastatic renal cell carcinoma; OR
- Macular degeneration.

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. Patients with HMO's (except IHC) will have to make arrangements with their HMO for coverage. Provider will bill with J code J9035, NDC number, and PA number.

AUTHORIZATION:

Initial prior is for 1 year

RE-AUTHORIZATION:

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

01/27/2012

<http://health.utah.gov/medicaid/pharmacy>