Prescriber Criteria Form

Zirabev BDC 2026 PA Fax 3944-A v2 010126.docx
Zirabev (bevacizumab-bvzr)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Zirabev (bevacizumab-bvzr).

Drug Name:
Zirabev (bevacizumab-bvzr)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.

B vs D CRITERIA FOR DETERMINATION			
1	Is the requested drug being supplied from the practitioner and/or office stock supply and billed as part of a practitioner service (i.e., the drug is being furnished "incident to a practitioner's service")? [If yes, then no further questions.]	Yes	No
CRITERIA FOR APPROVAL			
2	Does the patient have any of the following diagnoses: A) colorectal cancer (CRC), B) non-squamous non-small cell lung cancer (NSCLC), C) glioblastoma, D) renal cell carcinoma (RCC), E) cervical cancer, F) ovarian cancer, G) fallopian tube cancer, H) primary peritoneal cancer, I) hepatocellular carcinoma (HCC)? [If yes, then no further questions.]	Yes	No
3	Does the patient have any of the following diagnoses: A) ampullary adenocarcinoma, B) appendiceal adenocarcinoma, C) central nervous system (CNS) cancers (including pediatric diffuse high-grade gliomas), D) pleural mesothelioma, E) peritoneal mesothelioma, F) soft tissue sarcoma, G) uterine neoplasms, H) endometrial carcinoma, I) vulvar cancers, J) small bowel adenocarcinoma, K) vaginal cancer, L) pericardial mesothelioma, M) tunica vaginalis testis mesothelioma? [If yes, then no further questions.]	Yes	No

4	Does the patient have a diagnosis of any of the following ophthalmic-related disorders: A) diabetic macular edema, B) neovascular (wet) age-related macular degeneration (includes polypoidal choroidopathy and retinal angiomatous proliferation subtypes), C) macular edema following retinal vein occlusion (RVO), D) proliferative diabetic retinopathy, E) choroidal neovascularization (CNV), F) neovascular glaucoma, G) retinopathy of prematurity?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____