

Jurisdiction Specific Medicare Part B Avastin

Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated. Over-the-counter (OTC) products are not included unless otherwise stated.

Brand Name	Generic Name
Avastin	bevacizumab
Alymsys	bevacizumab-maly
Jobevne	bevacizumab-nwgd
Mvasi	bevacizumab-awwb
Vegzelma	bevacizumab-adcd
Zirabev	bevacizumab-bvzr

Covered Uses

The indications below are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

The FDA-labeled indications and recognized compendia (off-label) uses are below:

- Metastatic colorectal cancer (mCRC)
- First-line non-squamous non-small cell lung cancer (NSCLC)
- Recurrent glioblastoma
- Metastatic renal cell carcinoma (mRCC)
- Cervical cancer

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- Ovarian, fallopian tube, primary peritoneal cancer
- Hepatocellular carcinoma (HCC)
- Advanced gastric cancer
- Liver cancer
- Breast cancer
- Central nervous system (CNS) cancers
- Necrosis of central nervous system due to exposure to ionizing radiation
- Pleural mesothelioma, Peritoneal mesothelioma, pericardial mesothelioma, tunica vaginalis testis mesothelioma
- Soft tissue sarcoma
- Endometrial carcinoma
- Vulvar cancer
- Vaginal Cancer
- Kaposi sarcoma
- Choroidal neovascularization
- Diabetic macular edema
- Retinal vein occlusion with macular edema
- Neovascular glaucoma
- Neovascular (wet) age-related macular degeneration
- Proliferative diabetic retinopathy
- Retinopathy of prematurity
- Hereditary hemorrhagic telangiectasia syndrome
- Small bowel adenocarcinoma
- Ampullary adenocarcinoma
- Appendiceal neoplasms and cancers
- Anal adenocarcinoma

Compendial Uses – ICD-10 codes supported by the Medicare Administrative Contractor:

The list of covered ICD-10 codes is prohibitively long to include within this policy. A complete list can be found at: <https://www.cms.gov/medicare-coverage-database/indexes/national-and-local-indexes.aspx>.

All other indications will be assessed on an individual basis. Submissions for indications other than those listed in this criteria should be accompanied by supporting evidence from Medicare approved compendia.

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Coverage Criteria

Colorectal Cancer⁴⁻¹⁴

Authorization of 12 months may be granted for treatment of colorectal cancer, including anal adenocarcinoma.

Appendiceal Neoplasms and Cancers¹⁰

Authorization of 12 months may be granted for treatment of appendiceal neoplasms and appendiceal cancers (including appendiceal adenocarcinoma, goblet cell adenocarcinoma, undifferentiated carcinoma not otherwise specified, and low-grade and high-grade appendiceal mucinous neoplasm).

Non-Small Cell Lung Cancer⁴⁻¹¹

Authorization of 12 months may be granted for treatment of non-small cell lung cancer.

Renal Cell Cancer⁴⁻¹¹

Authorization of 12 months may be granted for treatment of renal cell cancer.

Cervical Cancer⁴⁻¹¹

Authorization of 12 months may be granted for treatment of cervical cancer.

Vaginal Cancer¹⁰

Authorization of 12 months may be granted for treatment of vaginal cancer.

Ovarian Cancer/Fallopian Tube Cancer/Primary Peritoneal Cancer⁴⁻¹¹

Authorization of 12 months may be granted for treatment of epithelial ovarian cancer, fallopian tube cancer, primary peritoneal cancer, and malignant sex cord stromal tumors.

Hepatocellular Carcinoma^{4,10}

Authorization of 12 months may be granted for treatment of hepatocellular carcinoma (HCC).

Gastric Cancer¹¹

Authorization of 12 months may be granted for treatment of gastric cancer.

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Liver Cancer²

Authorization of 12 months may be granted for treatment of liver cancer.

Breast Cancer¹¹

Authorization of 12 months may be granted for treatment of breast cancer.

Central Nervous System (CNS) Cancer^{10,11}

Authorization of 12 months may be granted for treatment of central nervous system (CNS) cancer, including glioblastoma, diffuse high grade gliomas, IDH mutant astrocytoma (WHO Grade 2, 3, or 4), oligodendroglioma (WHO Grade 2 or 3), intracranial and spinal ependymoma (excluding subependymoma), metastatic spine tumors, limited and extensive brain metastases, circumscribed glioma, medulloblastoma, primary central nervous system lymphoma, primary spinal cord tumors, meningiomas, H3-mutated high-grade glioma, high-grade astrocytoma with piloid features (HGAP), and pleomorphic xanthoastrocytoma (PXA) (WHO Grade 2 or 3).

Necrosis of Central Nervous System Due to Exposure to Ionizing Radiation¹¹

Authorization of 3 months may be granted for treatment of central nervous system necrosis due to exposure to ionizing radiation.

Mesothelioma^{2, 10,11}

Authorization of 12 months may be granted for treatment of pleural mesothelioma, peritoneal mesothelioma, pericardial mesothelioma, and tunica vaginalis testis mesothelioma.

Soft Tissue Sarcoma^{10,15}

Authorization of 12 months may be granted for treatment of angiosarcoma or solitary fibrous tumor/hemangiopericytoma.

Endometrial Carcinoma¹⁰

Authorization of 12 months may be granted for treatment of endometrial carcinoma.

Vulvar Cancer¹⁰

Authorization of 12 months may be granted treatment of vulvar cancer.

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Kaposi Sarcoma²

Authorization of 12 months may be granted treatment of Kaposi sarcoma.

Choroidal Neovascularization¹¹

Authorization of 12 months may be granted for the treatment of choroidal neovascularization.

Diabetic Macular Edema¹¹

Authorization of 12 months may be granted for the treatment of diabetic macular edema.

Retinal Vein Occlusion with Macular Edema¹¹

Authorization of 12 months may be granted for the treatment of macular edema following retinal vein occlusion.

Neovascular Glaucoma¹¹

Authorization of 12 months may be granted for the treatment of neovascular glaucoma.

Neovascular (Wet) Age-Related Macular Degeneration¹¹

Authorization of 12 months may be granted for the treatment of neovascular (wet) age-related macular degeneration.

Proliferative Diabetic Retinopathy¹¹

Authorization of 12 months may be granted for the treatment of proliferative diabetic retinopathy.

Retinopathy of Prematurity¹¹

Authorization of 12 months may be granted for the treatment of retinopathy of prematurity.

Hereditary Hemorrhagic Telangiectasia Syndrome¹¹

Authorization of 12 months may be granted for members with hereditary hemorrhagic telangiectasia syndrome.

Small Bowel Adenocarcinoma¹⁰

Authorization of 12 months may be granted for the treatment of small bowel adenocarcinoma.

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Ampullary Adenocarcinoma¹⁰

Authorization of 12 months may be granted for treatment of intestinal-type ampullary adenocarcinoma that is progressive or metastatic.

All Other Indications²

Authorization of 12 months may be granted for the treatment of all other approvable indications listed in LCA A52370.

Dosage and Administration

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

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