

Physician Standard Request Form Avastin® (bevacizumab)

Fax to PerformRx Pharmacy Services at 877-693-8280, or to speak to a representative call 800-578-0898. *Form must be completed for processing.*
Urgent fax is 877-693-8476.



Patient Name: _____

Plan ID#: _____

Address: _____

Apt # or Suite #: _____

City: _____ State: _____

Zip Code: _____

Phone #: _____ Height: _____ Weight: _____ lbs = _____ Kg

Birth Date: _____

Physician Name: _____

NPI #: _____

Address: _____

Apt # or Suite #: _____

City: _____ State: _____

Zip Code: _____

Contact Person: _____ Phone #: _____

Fax #: _____

Physician Signature: _____ Date: _____

For **initial therapy** requests please fill out **Part A and B only** and for **renewal therapy request** please fill out **Part B and C**
Attach diagnostic test results with request. Four weeks of therapy will be approved with 1 refill (total 8 weeks of therapy) for initial and reauthorization request. Contact the pharmacy to have refills processed and medications shipped to the office. Allow 2 business days for delivery.

Part A

- Does the patient have colorectal cancer? **(circle answer)** Yes or No
If Yes, indicate how this was diagnostically determined (i.e. CT scan, colonoscopy etc) _____
- Does the patient have metastatic colorectal cancer? **(circle answer)** Yes or No
If Yes, indicate the area of metastasis (liver and/or lung and/or abdominal peritoneal) _____
- If the patient has metastatic cancer, is the cancer resectable? **(circle answer)** Yes or No or N/A
If No, provide medical reason for why cancer is not resectable: _____
- If the patient does not have metastatic colorectal cancer, is the colorectal cancer resectable? **(circle answer)** Yes or No or N/A
If No, provide medical reason for why cancer is not resectable: _____
- Has the patient had a severe hemorrhage or hemoptysis in the past six months requiring medical intervention? **(circle answer):** Yes or No
If yes, explain _____
- Based on clinical assessment indicate the patients performance status: **(circle answer)** 0 1 2 3 4 5
- Is the member enrolled in a clinical trial? **(circle answer)** Yes or No.

Part B

- Has the patient received any surgical procedure(s) in the past 28 days? **(circle answer)** Yes or No
If yes, please explain: (attach copy of description of the procedure that was performed): _____
- Please provide one blood pressure reading and the corresponding date within the past 30 days _____
- Please indicate the result of a urine protein dipstick reading and/or a 24-hour urine collection done within the past 30 days. _____
- Is the patient receiving a 5-fluorouracil based drug regimen? **(circle answer)** Yes or No
If no, please explain why a 5-FU regimen is not to be given _____
If yes, indicate the 5-FU regimen _____
- Dose prescribed: _____ Start date of therapy: _____ Sig: _____

Part C

- Has the patient experienced a severe hemorrhagic event requiring medical intervention in the past 8 weeks? **(circle answer)** Yes or No
If yes, please explain _____
- Has the patient developed a gastrointestinal (GI) bleed due to GI perforation, abscess, wound dehiscence, or wound healing complications in the past 8 weeks? **(circle answer)** Yes or No
If yes, please explain _____
- Has the patient been receiving and tolerating Avastin® therapy for the past 8 weeks? **(circle answer)** Yes or No
If no, please explain _____
- If the patient has been on treatment for greater than 12 weeks, has the patient shown a beneficial response to the therapy? **(circle answer)** Yes or No
If yes, please explain _____