Clinical Policy: Bevacizumab (Avastin, Mvasi, Zirabev)

Reference Number: AZ.CP.PHAR.93
Effective Date: 09.01.20
Last Review Date: 11.20
Line of Business: Arizona Medicaid (AzCH-CCP and Care1st) Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Bevacizumab (Avastin®), bevacizumab-awwb (Mvasi®), bevacizumab-bvzr (Zirabev™) are vascular endothelial growth factor-specific angiogenesis inhibitors.

AHCCCS preferred drugs in this class include: Bevacizumab (Avastin®) **brand only**.

AHCCCS non-preferred drugs in this class include: bevacizumab-awwb (Mvasi®), bevacizumab-bvzr (Zirabev™).

FDA approved indications

Avastin, Mvasi, and Zirabev are indicated for the treatment of:
- Metastatic colorectal cancer, in combination with intravenous 5-fluorouracil (5-FU)-based chemotherapy for first- or second-line treatment
- Metastatic colorectal cancer, in combination with fluoropyrimidine-irinotecan- or fluoropyrimidine-oxaliplatin-based chemotherapy for second-line treatment in patients who have progressed on a first-line bevacizumab product-containing regimen
- Unresectable, locally advanced, recurrent or metastatic non-squamous non-small cell lung cancer (NSCLC), in combination with carboplatin and paclitaxel for first-line treatment
- Recurrent glioblastoma in adults
- Metastatic renal cell carcinoma (RCC) in combination with interferon alfa
- Persistent, recurrent, or metastatic cervical cancer, in combination with paclitaxel and cisplatin or paclitaxel and topotecan

Avastin is also indicated for the treatment of:
- Epithelial ovarian, fallopian tube, or primary peritoneal cancer:
  - In combination with carboplatin and paclitaxel, followed by Avastin as a single agent, for stage III or IV disease following initial surgical resection
  - In combination with paclitaxel, pegylated liposomal doxorubicin, or topotecan for platinum-resistant recurrent disease who received no more than 2 prior chemotherapy regimens
  - In combination with carboplatin and paclitaxel or carboplatin and gemcitabine, followed by Avastin as a single agent, for platinum-sensitive recurrent disease
- Hepatocellular carcinoma (HCC) in combination with atezolizumab for patients with unresectable or metastatic HCC who have not yet received prior systemic therapy.

Limitation(s) of use: Bevacizumab-products are not indicated for adjuvant treatment of colon cancer.

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of Arizona Complete Health-Complete Care Plan and Care1st that Avastin, Mvasi, and Zirabev are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. FDA-Approved Indications (must meet all)**:**

1. Diagnosis of one of the following (a-g):
   a. Colorectal cancer:
   b. Non-squamous non-small cell lung cancer:
   c. Glioblastoma;
   d. Metastatic renal cell carcinoma:
   e. Carcinoma of the cervix:
   f. Epithelial ovarian, fallopian tube, or primary peritoneal cancer;
   g. Hepatocellular carcinoma;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Member meets one of the following (a-g):
   a. For colorectal cancer, used in combination with 5-FU based chemotherapy;
      i. 5-FU based chemotherapy;
      ii. Irinotecan and oxaliplatin;
      iii. Irinotecan if previously received adjuvant FOLFOX (fluorouracil, leucovorin, and oxaliplatin) or CapeOX (capecitabine and oxaliplatin) within the past 12 months;
   b. For non-squamous non-small cell lung cancer, prescribed as one of the following (i-v):
      i. Single agent therapy;
      ii. In combination with carboplatin and paclitaxel for first line treatment of unresectable, locally advanced, recurrent or metastatic disease;
      iii. In combination with pemetrexed;
      iv. In combination with Tecentriq®;
      v. In combination with erlotinib for sensitizing EGFR mutation-positive histology, recurrent, advanced, or metastatic disease;
   c. For glioblastoma, patient has recurrent disease;
   d. For metastatic renal cell carcinoma, used as a single-agent or in combination with interferon alfa, everolimus, or erlotinib (for advanced papillary renal cell carcinoma including hereditary leiomyomatosis and renal cell cancer (HLRCC));

e. For cervical cancer, used in combination with paclitaxel and cisplatin or topotecan for the treatment of persistent, recurrent, or metastatic disease;
f. For epithelial ovarian, fallopian tube, or primary peritoneal cancer, one of the following (i, ii, iii, or iv):
   i. Prescribed in combination with carboplatin and paclitaxel, followed by bevacizumab as a single agent, for one of the following (1 or 2):
      1. Stage III or IV disease following initial surgical resection;
      2. Stage II-IV high-grade serous, low-grade serous, endometroid (Grade 1/2/3), clear cell carcinoma, or carcinosarcoma;
   ii. For platinum-resistant recurrent disease, prescribed in combination with paclitaxel, pegylated liposomal doxorubicin, topotecan, or cyclophosphamide;
   iii. For platinum-sensitive recurrent disease, prescribed in combination with carboplatin and paclitaxel, or carboplatin and gemcitabine, or carboplatin and liposomal doxorubicin, followed by bevacizumab as a single agent;
   iv. Prescribed as a single agent for clinical relapse in patients with stage II-IV malignant sex cord-stromal tumors;
g. For HCC, used in combination with Tecentriq® as first-line systemic therapy;

5. For Mvasi or Zirabev requests, member meets one of the following (a or b):
   a. Medical justification supports inability to use Avastin (e.g., contraindications to the excipients);*
      **Prior authorization may be required for Avastin.*
   b. Request is for Stage IV or metastatic cancer for a State with regulations against step therapy in advanced oncology settings *(see Appendix E*);
6. Request meets one of the following (a or b):*
   a. Dose does not exceed 15 mg/kg IV every 3 weeks or 10 mg/kg IV every 2 weeks;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Medicaid/HIM – 6 months
Commercial – Length of Benefit

B. Oncology - Non-FDA-Approved Indications (off-label) (must meet all)**:**

1. Diagnosis of one of the following conditions (a-l):
   a. Anaplastic gliomas;
   b. Breast cancer;
   c. Endometrial carcinoma;
   d. Intracranial and spinal ependymoma;
   e. Low-grade (WHO Grade II) infiltrative supratentorial astrocytoma/ oligodendroglioma;
   f. Malignant pleural mesothelioma;
   g. Medulloblastoma;
   h. Meningioma;

i. Metastatic spine tumors or brain metastases;
j. Primary central nervous system cancers;
k. Small bowel adenocarcinoma;
l. Soft tissue sarcoma – solitary fibrous tumor or angiosarcoma;
m. Vulvar cancer – squamous cell carcinoma;

2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. For Mvasi or Zirabev requests, medical justification supports inability to use Avastin (e.g., contraindications to the excipients);
   **Prior authorization may be required*
5. Dose is within FDA maximum limit for any FDA-approved indication or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).*
   **Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Medicaid/HIM – 6 months
Commercial – Length of Benefit

C. Ophthalmology - Non-FDA-Approved Indications (off-label) (must meet all)**:**

1. Diagnosis of one of the following conditions (a-g):
   a. Neovascular (wet) age-related macular degeneration;
   b. Macular edema following retinal vein occlusion;
   c. Diabetic macular edema;
   d. Proliferative diabetic retinopathy;
   e. Neovascular glaucoma;
   f. Choroidal neovascularization associated with: angioid streaks, no known cause, inflammatory conditions, high pathologic myopia, or ocular histoplasmosis syndrome;
   g. Diabetic retinopathy associated with ocular neovascularization (choroidal, retinal, iris);
2. Age ≥ 18 years;
3. Request meets one of the following (a or b):
   a. Dose does not exceed 2.5 mg/dose;
   b. Dose is within FDA maximum limit for any FDA-approved indication or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration:
Medicaid/HIM – 6 months
Commercial – Length of Benefit

D. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): AZ.CP.PMN.53 for Arizona Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Documentation supports that member is currently receiving Avastin, Mvasi, or Zirabev for a covered oncology indication listed in section I and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For Mvasi or Zirabev requests for non-ophthalmology uses, member meets one of the following (a or b):
   a. Medical justification supports inability to use Avastin (e.g., contraindications to the excipients);*
   **Prior authorization may be required*
   b. Request is for Stage IV or metastatic cancer for a State with regulations against step therapy in advanced oncology settings *(see Appendix E*);
4. If request is for a dose increase, request meets one of the following (a or b):*
   a. New dose does not exceed 15 mg/kg IV every 3 weeks or 10 mg/kg IV every 2 weeks;
   b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).
   **Prescribed chemotherapy regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Medicaid/HIM – 6 months
Commercial – Length of Benefit

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): AZ.CP.PMN.53 for Arizona Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – AZ.CP.PMN.53 for Arizona Medicaid.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

55-FU: fluorouracil
FDA: Food and Drug Administration
FOLFIRI: fluorouracil, leucovorin, irinotecan
FOLFOX: fluorouracil, leucovorin, oxaliplatin
HCC: hepatocellular carcinoma
HLRCC: hereditary leiomyomatosis and renal cell cancer
NCCN: National Comprehensive Cancer Network

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Metastatic carcinoma of the colon or rectum		
FOLFOX4 = Infusional 5-FU/leucovorin/ oxaliplatin	Oxaliplatin 85 mg/m^2 IV over 2 hours day 1; leucovorin 200 mg/m^2 IV over 2 hours days 1 & 2, followed by 5-FU 400 mg/m^2 IV bolus over 2-4 minutes, followed by 600 mg/m^2 IV 5-FU continuous infusion over 22 hours on days 1 & 2. Repeat cycle every 14 days.	Varies
FOLFIRI = Infusional 5-FU/ leucovorin/Camptosar® (irinotecan)	Camptosar 180 mg/m^2 IV over 90 minutes day 1; Leucovorin 400 mg/m^2 IV over 2 hours day 1 followed by 5-FU 400 mg/m^2 IV bolus over 2-4 minutes, followed by 2.4 gm/m^2 IV 5-FU continuous infusion over 46 hours. Repeat cycle every 14 days.	Varies
capecitabine (Xeloda®)	2500 mg/m^2 PO BID for 2 weeks; repeat cycles of 2 weeks on and 1 week off. For patients who cannot tolerate intensive therapy.	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
IROX = oxaliplatin/ Camptosar (irinotecan)	Oxaliplatin 85 mg/m^2 IV followed by Camptosar 200 mg m^2 IV over 30-90 minutes every 3 weeks	Varies
Camptosar (irinotecan)	180 mg/m^2 IV every 2 weeks or 300-350 mg/m^2 IV every 3 weeks	Varies
NSCLC		
cisplatin carboplatin paclitaxel docetaxel vinorelbine gemcitabine etoposide irinotecan vinblastine mitomycin ifosfamide pemetrexed disodium (Alimta®) (2nd line) erlotinib (Tarceva®) Tecentriq® (atezolizumab)	Various doses	Varies
Ovarian Cancer		
carboplatin and paclitaxel	Carboplatin dosed at an area under the curve (AUC) of 5-7.5 and paclitaxel 175 mg/m^2 IV over 3 hours given every 3 weeks for 6 courses.	Varies
docetaxel taxotere and carboplatin	Docetaxel, 60-75 mg/m^2 IV over 1 hour plus carboplatin dosed at AUC of 5 to 6 every 3 weeks.	Varies
Glioblastoma Multiforme		
temozolomide (Temodar®)	Maintenance phase cycles: 150 mg-200 mg/m² PO days 1-5. Repeat every 28 days.	Varies
carmustine (Bicnu®)	150 mg to 200 mg/m² IV on day 1. Repeat every 6-8 weeks for one year or tumor progression.	Varies
Cervical Cancer		

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
cisplatin/paclitaxel	Paclitaxel: 135 mg/m^2 IV as a continuous infusion over 24 hours day 1 Cisplatin: 50 mg/m^2 IV on day 2 Repeat cycle every 21 days for up to a total of 6 cycles; responders may continue beyond 6 cycles	Varies
carboplatin/paclitaxel	Paclitaxel: 175 mg/m^2 IV followed by carboplatin AUC 5-6 IV Repeat every 21 days for up to 6 cycles	Varies
cisplatin/topotecan (Hycamtin®)	Topotecan: 10.75 mg/m^2/day IV on days 1, 2, and 3 Cisplatin: 50 mg/m^2 IV on day 1 only Repeat cycle every 21 days for up to a total of 6 cycles; responders may continue beyond 6 cycles	Varies
topotecan (Hycamtin®)/paclitaxel	Paclitaxel: 135 mg/m^2 IV continuous infusion over 24 hours day 1 Topotecan: 0.75 mg/m^2/day IV on days 1, 2, and 3 Repeat cycle every 21 days for up to a total of 6 cycles; responders may continue beyond 6 cycles	Varies

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

None reported

Appendix D: General Information

- The FDA revoked the approval of the breast cancer indication for Avastin (bevacizumab) on November 18, 2011. Avastin used for metastatic breast cancer has not been shown to provide a benefit, in terms of delay in the growth of tumors that would justify its serious and potentially life-threatening risks. Nor is there evidence that use of Avastin will either help women with breast cancer live longer or improve their quality of life. More information at: http://www.fda.gov/NewsEvents/Newsroom/ucm279485.htm
- Fatal pulmonary hemorrhage can occur in patients with NSCLC treated with chemotherapy and bevacizumab. The incidence of severe or fatal hemoptysis was 31% in patients with squamous histology and 2.3% with NSCLC excluding predominant squamous histology. Patients with recent hemoptysis should not receive bevacizumab.

Appendix E: Dose Rounding Guidelines

Weight-based Dose Range	Vial Quantity Recommendation
≤ 104.99 mg	1 vial of 100 mg/4 mL
105 mg-209.99 mg	2 vials of 100 mg/4 mL
210 mg-314.99 mg	3 vials of 100 mg/4 mL
315 mg-419.99 mg	1 vial of 400 mg/16 mL
420 mg-524.99 mg	1 vial of 100 mg/4 mL and 1 vial of 400 mg/16 mL
525 mg-629.99 mg	2 vials of 100 mg/4 mL and 1 vial of 400 mg/16 mL
630 mg-734.99 mg	3 vials of 100 mg/4 mL and 1 vial of 400 mg/16 mL
735 mg-839.99 mg	2 vials of 400 mg/16 mL
881 mg-944.99 mg	1 vials of 100 mg/4 mL and 2 vials of 400 mg/16 mL
945 mg-1,049.99 mg	2 vials of 100 mg/4 mL and 2 vials of 400 mg/16 mL
1,050 mg-1,154.99 mg	3 vials of 100 mg/4 mL and 2 vials of 400 mg/16 mL
1,155 mg-1,259.99 mg	3 vials of 400 mg/16 mL
1,260 mg-1,364.99 mg	1 vials of 100 mg/4 mL and 3 vials of 400 mg/16 mL
1,365 mg-1,469.99 mg	2 vials of 100 mg/4 mL and 3 vials of 400 mg/16 mL
1,470 mg-1,574.99 mg	3 vials of 100 mg/4 mL and 3 vials of 400 mg/16 mL
1,575 mg-1,679.99 mg	4 vials of 400 mg/16 mL
1,680 mg-1,784.99 mg	1 vials of 100 mg/4 mL and 4 vials of 400 mg/16 mL
1,785 mg-1,889.99 mg	2 vials of 100 mg/4 mL and 4 vials of 400 mg/16 mL
1,890 mg-1,994.99 mg	3 vials of 100 mg/4 mL and 4 vials of 400 mg/16 mL
1,995 mg-2,099.99 mg	5 vials of 400 mg/16 mL

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Metastatic colorectal cancer	5 mg/kg or 10 mg/kg once every 14 days as an IV infusion in combination with a 5-FU based chemotherapy regimen until disease progression is detected. 5 mg/kg every 2 weeks or 7.5 mg/kg every 3 weeks when used in combination with a fluoropyrimidine-irinotecan or fluoropyrimidine-oxaliplatin based chemotherapy regimen in patients who have progressed on a first-line Avastin-containing regimen	15 mg/kg IV every 3 weeks or 10 mg/kg IV every 2 weeks
Non-squamous, non-small cell lung cancer	15 mg/kg IV infusion every 3 weeks with carboplatin/paclitaxel	15 mg/kg IV every 3 weeks or 10 mg/kg IV every 2 weeks
Ovarian cancer	15 mg/kg IV infusion every 3 weeks	15 mg/kg IV every 3 weeks or 10 mg/kg IV every 2 weeks
Platinum resistant ovarian cancer	10 mg/kg intravenously every 2weeks with weekly paclitaxel, liposomal doxorubicin, or topotecan	15 mg/kg IV every 3 weeks or 10 mg/kg IV every 2 weeks
HCC	15 mg/kg IV every 3 weeks plus Tecentriq 1,200 mg IV on the same day	15 mg/kg IV every 3 weeks
Clear cell renal carcinoma	10 mg/kg IV every 2 weeks with interferon alfa	15 mg/kg IV every 3 weeks or 10 mg/kg IV every 2 weeks
Glioblastoma multiforme, anaplastic astrocytoma, anaplastic oligodendroglioma	10 mg/kg IV every 2 weeks	15 mg/kg IV every 3 weeks or 10 mg/kg IV every 2 weeks
Soft tissue sarcoma	15 mg/kg IV infusion every 3 weeks	15 mg/kg IV every 3 weeks or 10 mg/kg IV every 2 weeks
Cervical cancer	15 mg/kg IV infusion every 3 weeks (in combination with paclitaxel and either cisplatin or topotecan) until disease progression or unacceptable toxicity	15 mg/kg IV every 3 weeks or 10 mg/kg IV every 2 weeks

Indication	Dosing Regimen	Maximum Dose
Neovascular (wet) macular degeneration	1.25 to 2.5 mg administered by intravitreal injection every 4 weeks	2.5 mg/dose
Neovascular glaucoma	1.25 mg administered by intravitreal injection every 4 weeks	2.5 mg/dose
Macular edema secondary to retinal vein occlusion	1 mg to 2.5 mg administered by intravitreal injection every 4 weeks	2.5 mg/dose
Proliferative diabetic retinopathy	1.25 mg administer by intravitreal injection 5 to 20 days before vitrectomy	2.5 mg/dose
Diabetic macular edema	1.25 mg administered by intravitreal injection	2.5 mg/dose
Malignant mesothelioma of pleura	15 mg/kg IV (plus pemetrexed 500 mg/m(2) IV and cisplatin 75 mg/m(2) IV) every 21 days for up to 6 cycles, followed by maintenance bevacizumab 15 mg/kg every 21 days until disease progression or unacceptable toxicity. All patients should receive folic acid 400 mcg orally daily and vitamin B12 1000 mcg IM every 3 weeks, both beginning 7 days prior to pemetrexed and continuing for 3 weeks following the last pemetrexed dose (off-label dosage).	2.5 mg/dose
Metastatic colorectal cancer in previously untreated elderly patients ineligible for oxaliplatin- or irinotecan-based chemotherapy	7.5 mg/kg IV on day 1 with capecitabine 1,000 mg/m2 orally twice daily on days 1 to 14, given every 3 weeks until disease progression.	15 mg/kg IV every 3 weeks or 10 mg/kg IV every 2 weeks.

VI. Product Availability

Single-use vials: 100 mg/4 mL, 400 mg/16 mL

VII. References

1. Avastin Prescribing Information. South San Francisco, CA: Genentech, Inc. May 2020. Available at: www.avastin.com. Accessed July 6, 2020.
2. Mvasi Prescribing Information. Thousand Oaks, CA: Amgen Inc. June 2019. Available at: https://www.mvasi.com/hcp. Accessed July 6, 2020.
3. Zirabev Prescribing Information. New York, NY: Pfizer Inc. June 2019. Available at: http://labeling.pfizer.com/ShowLabeling.aspx?id=11860. Accessed July 6, 2020.

4. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed July 6, 2020.
5. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2019. Available at: http://www.clinicalpharmacology-ip.com/.
6. American Academy of Ophthalmology Retina/Vitreous Panel. Preferred Practice Pattern® Guidelines. Age-Related Macular Degeneration. San Francisco, CA: American Academy of Ophthalmology; January 2015. Available at: www.aao.org/ppp. Accessed July 6, 2020.
7. American Academy of Ophthalmology Retina/Vitreous Panel. Preferred Practice Pattern® Guidelines. Retinal Vein Occlusions. San Francisco, CA: American Academy of Ophthalmology; November 2015. Available at: www.aao.org/ppp. Accessed July 6, 2020..
8. American Academy of Ophthalmology Retina/Vitreous Panel. Preferred Practice Pattern® Guidelines. Diabetic Retinopathy. San Francisco, CA: American Academy of Ophthalmology; December 2017. Available at: www.aao.org/ppp. Accessed July 6, 2020.
9. Hepatobiliary Cancers Version 3.2020. National Comprehensive Cancer Network Guidelines. Available at: https://www.nccn.org/professionals/physician_gls/pdf/hepatobiliary.pdf. Accessed July 6, 2020.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J9035	Injection, bevacizumab, 10 mg
C9257	Injection, bevacizumab, 0.25 mg
Q5107	Injection, bevacizumab-awwb, biosimilar, (Mvasi), 10 mg
Q5118	Injection, bevacizumab-bvcr, biosimilar, (Zirabev), 10 mg

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

The following is a list of diagnosis codes that support coverage for the applicable covered procedure code(s).

ICD-10-CM Code	Description
A18.53	Tuberculosis chorioretinitis
C17.0 – C17.9	Malignant neoplasm of small intestine
C18.0 – C18.9	Malignant neoplasm of colon
C19	Malignant neoplasm of rectosigmoid junction
C20	Malignant neoplasm of rectum
C21.8	Malignant neoplasm of overlapping sites of rectum, anus and anal canal

ICD-10-CM Code	Description
C33	Malignant neoplasm of trachea
C34.00 – C34.02	Malignant neoplasm of main bronchus
C34.10 – C34.12	Malignant neoplasm of upper lobe, bronchus or lung
C34.2	Malignant neoplasm of middle lobe, bronchus or lung
C34.30 – C34.32	Malignant neoplasm of lower lobe, bronchus or lung
C34.80 – C34.82	Malignant neoplasm of overlapping sites of bronchus and lung
C34.90 – C34.92	Malignant neoplasm of unspecified part of bronchus or lung
C48.0 – C48.8	Malignant neoplasm of retroperitoneum and peritoneum
C49.0 – C49.9	Malignant neoplasm of other connective and soft tissue
C50.01 – C50.929	Malignant neoplasm of breast
C53.0 – C53.9	Malignant neoplasm of cervix uteri
C54.0 – C55	Malignant neoplasm of corpus uteri
C56.1 – C56.9	Malignant neoplasm of ovary
C57.0 – C57.9	Malignant neoplasm of other and unspecified female genital organs
C64.1 – C64.9	Malignant neoplasm of kidney, except renal pelvis
C65.1 – C65.9	Malignant neoplasm of renal pelvis
C70.0 – C70.9	Malignant neoplasm of meninges
C71.0 – C71.9	Malignant neoplasm of brain
C72.0 – C72.9	Malignant of spinal cord, cranial neoplasm nerves and other parts of central nervous system
D32.0 – D32.9	Benign neoplasm of meninges
D42.0 – D42.9	Neoplasm of uncertain behavior of meninges
E08.311, E08.3211 – E08.3219, E08.3311 – E08.3319, E08.3411 – E08.3419, E08.3511 – E08.3519	Diabetes mellitus due to underlying condition with diabetic retinopathy with macular edema
E09.311, E09.3211 – E09.3219, E09.3311 – E09.3319, E09.3411 – E09.3419, E09.3511 – E093519	Drug or chemical induced diabetes mellitus with diabetic retinopathy with macular edema
E10.311, E10.3211 – E10.3219, E10.3311 – E10.3319, E10.3411 – E10.3419, E10.3511 – E10.3519	Type 1 diabetes mellitus with diabetic retinopathy with macular edema
E11.311, E11.3211 – E11.3219, E11.3311 – E11.3319, E11.3411 – E11.3419, E11.3511 – E11.3519	Type 2 diabetes mellitus with diabetic retinopathy with macular edema

ICD-10-CM Code	Description
E13.311, E13.3211 – E13.3219, E13.3311 – E13.3319, E13.3411 – E13.3419, E13.3511 – E13.3519	Other specified diabetes mellitus with diabetic retinopathy with macular edema
H16.401 – H16.449	Corneal neovascularization
H30.001 – H30.049	Focal chorioretinal inflammation
H30.101 – H30.139	Disseminated chorioretinal inflammation
H30.891 – H30.899	Other chorioretinal inflammations
H30.90 – H30.93	Unspecified chorioretinal inflammations
H32	Chorioretinal disorders in diseases classified elsewhere
H34.8110 – H 34.8192	Central retinal vein occlusion
H34.8310 – H34.8392	Tributary (branch) retinal vein occlusion
H35.051 – H35.059	Retinal neovascularization, unspecified
H35.141 – H35.169	Retinopathy of prematurity, stages 3 through 5
H35.3210 – H35.3293	Exudative age-related macular degeneration
H35.33	Angioid streaks of macula
H35.81	Retinal edema
H40.50X0-H40.53X4	Glaucoma secondary to other eye disorders [associated with vascular disorders of eye]
H44.20-H44.23	Degenerative myopia
H44.2A1-H44.2A9	Degenerative myopia with choroidal neovascularization
I67.89	Other cerebrovascular disease
Z85.038	Personal history of other malignant neoplasm of large intestine
Z85.048	Personal history of other malignant neoplasm of rectum, rectosigmoid junction, and anus
Z85.068	Personal history of other malignant neoplasm of small intestine
Z85.118	Personal history of other malignant neoplasm of bronchus and lung
Z85.3	Personal history of malignant neoplasm of breast
Z85.41	Personal history of malignant neoplasm of cervix uteri
Z85.42	Personal history of malignant neoplasm of other parts of uterus
Z85.43	Personal history of malignant neoplasm of ovary
Z85.44	Personal history of malignant neoplasm of other female genital organs
Z85.528	Personal history of other malignant neoplasm of kidney
Z85.53	Personal history of malignant neoplasm of renal pelvis
Z85.841	Personal history of malignant neoplasm of brain
Z85.848	Personal history of malignant neoplasm of other parts of nervous tissue

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created based on CP.PHAR.93 due to Arizona Medicaid preference of brand Avastin.	8.25.20	7.20
4Q 2020 annual review: removed AIDS-related Kaposi sarcoma as an off label use as it is no longer NCCN supported; added additional NCCN supported regimens for colorectal cancer, non-squamous non-small cell lung cancer, renal cell carcinoma, cervical cancer, and epithelial ovarian, fallopian tube, or primary peritoneal cancer; added to Section IB metastatic spine tumors or brain metastases and vulvar cancer diagnoses which are supported by NCCN; added appendix F: dose rounding guidelines; added reference to appendix F within criteria; references reviewed and updated.	10.20	10.20
Added Care1st logo. Added verbiage to specify that criteria also applies to Care1st.	5.10.21	04.21

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or

regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.