MetroPlus Health

Policy and Procedure

Title: UM-PT014 Bevacizumab	**Division: Medical Management** **Department: Pharmacy**
Approval Date: 4/28/2023	**LOB: Medicaid, HIV SNP, HARP, QHP, EP, Gold, GoldCare, CHP**
Effective Date: 4/28/2023	**Policy Number: UM-PT014**
Review Date: 5/29/2024	**Cross Reference Number:**
Retired Date:	**Page 1 of 6**

I. POLICY DESCRIPTION:

Antineoplastic Agent, Monoclonal Antibody, Vascular Endothelial Growth Factor (VEGF) Inhibitor – Avastin (bevacizumab); Alymsys (bevacizumab-maly); Mvasi (bevacizumab-awwb); Vegzelma (bevacizumab-adcd); Zirabev (bevacizumab-bvzr)

Vascular Endothelial Growth Factor (VEGF) Inhibitors	
Preferred	Mvasi (bevacizumab-awwb)
Non-preferred	Avastin (bevacizumab) Alymsys (bevacizumab-maly) Vegzelma (bevacizumab-adcd) Zirabev (bevacizumab-bvzr)

No authorization needed for ocular use.

II. RESPONSIBLE PARTIES:

Medical Management Administration, Pharmacy Department, Utilization Management, Integrated Care Management, Claims Department

III. DEFINITIONS:

Bevacizumab and its biosimilars are classified as a recombinant, humanized monoclonal antibody which binds to, and neutralizes, vascular endothelial growth factor (VEGF), preventing its association with endothelial receptors, Flt-1 and KDR. VEGF binding initiates angiogenesis (endothelial proliferation and the formation of new blood vessels). The inhibition of microvascular growth is believed to retard the growth of all tissues (including metastatic tissue).

IV. POLICY:

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

Chart notes must be submitted to confirm diagnosis and previous treatment(s).

Non-preferred drugs will be approved when ALL of the following criteria are met:

A. ONE of the following:
- **a.** Documented trial and failure with ALL preferred agents listed above;

OR
- **b.** The preferred agents are not appropriate for the member and clinical rationale is provided;

AND

B. Indication, dose, frequency and duration is in accordance with FDA label or compendial supported.

AND

C. Authorization is for no more than 12 months

V. LIMITATIONS/ EXCLUSIONS:

The use of bevacizumab is considered to be experimental and investigational if prescribed for indications that have not been approved by the FDA and will not be covered under this policy.

Bevacizumab and bevacizumab biosimilars should not be administered for 28 days following major surgery and until surgical wounds are fully healed.

VI. APPLICABLE PROCEDURE CODES:

CPT	Description
J9035	Injection, bevacizumab, 10 mg (Avastin)
Q5107	Injection, bevacizumab-awwb, biosimilar, 10 mg (Mvasi)
Q5118	Injection, bevacizumab-bvzr, biosimilar, 10 mg (Zirabev)
Q5126	Injection, bevacizumab-maly, biosimilar, 10 mg (Alymsys)
Q5129	Injection, bevacizumab-adcd, biosimilar, 10 mg (Vegzalma)

VII. REFERENCES:

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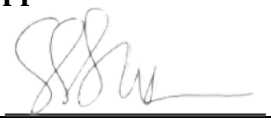
REVISION LOG:

REVISIONS	INITIAL	DATE
Creation date	JC	4/28/2023
Update	AKC	11/28/2023
Update	AKC	5/29/2024

Approved: **Date:** 5/29/2024 Suzana Patel **Suzana Patel, PharmD** **Senior Director of Pharmacy**	**Approved:** **Date:**  04.03.26 **Sanjiv Shah, MD** **Chief Medical Officer**

Medical Guideline Disclaimer:

 The treating physician or primary care provider must submit MetroPlus Health Plan clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, Metroplus Health Plan will not be able to properly review the request for prior authorization. The clinical review criteria expressed in this policy reflects how MetroPlus Health Plan determines whether certain services or supplies are medically necessary. MetroPlus Health Plan established the clinical review criteria based upon a review of currently available clinical information(including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). MetroPlus Health Plan expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered andor paid for by MetroPlus Health Plan, as some programs exclude coverage for services or supplies that MetroPlus Health Plan considers medically necessary. If there is a discrepancy between this guidelines and a member's benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members.

All coding and website links are accurate at time of publication. MetroPlus HealthPlan has adopted the herein policy in providing management, administrative and other services to our members, related to health benefit plans offered by our organization.