

**Complete Patient and Physician information (PLEASE PRINT)**

STEP 1	Member Name:	Physician Name:
	Address:	Address:
	Member ID:	Phone #:
	Member DOB:	Fax #:

**If Applicable:** Pharmacy Name: \_\_\_\_\_  
 Pharmacy Phone: \_\_\_\_\_

**Complete the Clinical Assessment:**

STEP 2	Diagnosis	<input type="checkbox"/> Metastatic Colorectal Cancer <input type="checkbox"/> Non-Squamous, Non-Small Cell Lung Cancer (NSCLC) – unresectable, locally advanced, recurrent or metastatic.	<input type="checkbox"/> Neovascular (wet) Age-related Macular Degeneration (AMD) <input type="checkbox"/> HER-2 Negative Metastatic Breast Cancer <input type="checkbox"/> Other (please state):
	Clinical Consideration	<input type="checkbox"/> Avastin is being used in combination with a 5-FU chemotherapy regimen. <input type="checkbox"/> Avastin is being used in conjunction with carboplatin and paclitaxel. <input type="checkbox"/> Other (please state):	<input type="checkbox"/> Avastin has been prepared by a compounding pharmacy. <input type="checkbox"/> For intravitreal injections, Avastin is being administered by an Ophthalmologist.
	Supporting Documentation	Diagnosis: ICD-9 Code #/ Description (required):  Please attach a copy of the prescription or provide ALL of the information below: Avastin <sup>®</sup> (bevacizumab) Strength _____ Sig _____ Qty _____ Refills _____  Please attach all relevant medical records and test results. <p style="text-align: center;"><b>Incomplete forms will not be processed.</b></p>	

STEP 3 **I certify that the above is correct and accurate to the best of my knowledge (please sign and date).**

\_\_\_\_\_  
 Prescriber Signature Date

STEP 4 **Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk:**

**970-248-5034**

Pharmacy Technician initials \_\_\_\_\_ Date Initiated \_\_\_\_\_

**Confidentiality Notice:**

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