Clinical Policy: Bevacizumab (Alymsys, Avastin, Avzivi, Jobevne, Mvasi, Vegzelma, Zirabev)

Reference Number: LA.PHAR.93
Effective Date: 04.21
Last Review Date: 01.26.26
Line of Business: Medicaid

Coding Implications
Revision Log

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

****Please note: This policy is for medical benefit****

Description

Bevacizumab (Avastin®) and its biosimilars [bevacizumab-maly (Alymsys®), bevacizumab-tnjn (Avzivi®), bevacizumab-nwgd (Jobevne™), bevacizumab-awwb (Mvasi®), bevacizumab-adcd (Vegzelma®), bevacizumab-bvzr (Zirabev™)] are vascular endothelial growth factor-specific angiogenesis inhibitors.

FDA Approved Indication(s)

Avastin, Alymsys, Avzivi, Jobevne, Mvasi, Vegzelma, and Zirabev are indicated for the treatment of:

- Metastatic colorectal cancer (CRC), in combination with intravenous 5-fluorouracil (5-FU)-based chemotherapy for first- or second-line treatment
- Metastatic CRC, 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
- Epithelial ovarian, fallopian tube, or primary peritoneal cancer:
  - In combination with carboplatin and paclitaxel, followed by Avastin/Jobevne/Mvasi/Vegzelma/Zirabev 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/Jobevne/Mvasi/Vegzelma/Zirabev as a single agent, for platinum-sensitive recurrent disease

Avastin is also indicated for the treatment of:

- 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 Louisiana Healthcare Connections that Avastin, Alymsys, Avzivi, Jobevne, Mvasi, Vegzelma, 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. CRC;
   b. Non-squamous NSCLC;
   c. Glioblastoma;
   d. RCC;
   e. Cervical cancer;
   f. Epithelial ovarian, fallopian tube, or primary peritoneal cancer;
   g. HCC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Member meets one of the following (a-g):
   a. For CRC, both of the following (i and ii):
      i. Disease is advanced, metastatic, or unresectable;
      ii. Prescribed in combination with one of the following (1-6):
         1) 5-FU/leucovorin or capecitabine-based chemotherapy;
         2) IROX (irinotecan and oxaliplatin);
         3) FOLFOX (fluorouracil, leucovorin, and oxaliplatin) or CapeOX (capecitabine and oxaliplatin);
         4) Irinotecan or FOLFIRI (fluorouracil, leucovorin, and irinotecan);
         5) FOLFIRINOX (fluorouracil, leucovorin, irinotecan, and oxaliplatin);
         6) Lonsurf® if previously progressed through all available regimens;
   b. For non-squamous NSCLC, both of the following (i and ii):
      i. Disease is unresectable, recurrent, advanced, or metastatic;
      ii. Prescribed in one of the following ways (1-5):
         1) As single agent therapy;
         2) In combination with carboplatin and paclitaxel;
         3) In combination with pemetrexed with or without carboplatin or cisplatin;
         4) In combination with Tecentriq® with or without carboplatin and paclitaxel;
         5) In combination with erlotinib for sensitizing EGFR mutation-positive histology (i.e., EGFR exon 19 deletion or exon 21 L858R);
   c. For glioblastoma, member has recurrent disease or requires symptom management;

d. For RCC, both of the following (i and ii):
   i. Disease is relapsed or metastatic;
   ii. Prescribed in one of the following ways (1, 2, or 3):
      1) As a single-agent;
      2) In combination with everolimus;
      3) For advanced papillary RCC, including hereditary leiomyomatosis and renal cell carcinoma-associated RCC, only: In combination with erlotinib;
e. For cervical cancer, both of the following (i and ii):
   i. Disease is persistent, recurrent, or metastatic;
   ii. Prescribed in one of the following ways (1, 2, or 3):
      1) As a single agent;
      2) In combination with paclitaxel/cisplatin with or without Tecentriq, paclitaxel/carboplatin with or without Tecentriq, or paclitaxel/topotecan;
      3) In combination with Keytruda®, paclitaxel, and cisplatin/carboplatin for PD-L1-postive disease;
f. For epithelial ovarian, fallopian tube, or primary peritoneal cancer, prescribed in one of the following ways (i-v):
   i. As a single agent;
   ii. In combination with a platinum agent (e.g., carboplatin, oxaliplatin) and chemotherapy (e.g., docetaxel, paclitaxel), followed by bevacizumab as a single agent;
   iii. For maintenance in combination with Lynparza® (or Zejula® if unable to tolerate Lynparza) for stage II-IV disease;
   iv. For platinum-resistant persistent disease or recurrence, one of the following (1-5):
      1) In combination with paclitaxel, liposomal doxorubicin, topotecan, gemcitabine, or cyclophosphamide;
      2) In combination with carboplatin and paclitaxel, or carboplatin and gemcitabine, or carboplatin and liposomal doxorubicin;
      3) In combination with cyclophosphamide and Keytruda;
      4) In combination with Ixempra® (if previously treated with a taxane);
      5) In combination with Elahere® (in folate receptor-alpha expressing tumors);
   v. For platinum-sensitive persistent disease or recurrence, one of the following (1, 2, or 3):
      1) In combination with carboplatin and paclitaxel, or carboplatin and gemcitabine, or carboplatin and liposomal doxorubicin;
      2) In combination with Zejula as targeted therapy;
      3) In combination with Elahere in folate receptor-alpha expressing tumors;
g. For HCC, prescribed in combination with Tecentriq as one of the following (i or ii):
   i. First-line systemic therapy, and:
      1) Disease is unresectable or metastatic;
   ii. Subsequent-line systemic therapy if progression on or after systemic therapy;

5. For Alymsys, Avastin, Avzivi, Jobevne, or Vegzelma requests, member must use Mvasi or Zirabev^, unless both are contraindicated or clinically significant adverse effects are experienced;
   ^Prior authorization may be required for Mvasi and Zirabev
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 (*see Appendix E for dose rounding guidelines*);
   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: 12 months

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

1. Diagnosis of one of the following conditions (a-p):
   a. Glioma of one of the following types (i-vii):
      i. Oligodendroglioma that is IDH-mutant, 1p19q codeleted;
      ii. IDH-mutant astrocytoma;
      iii. Circumscribed glioma;
      iv. Pleomorphic xanthroastrocytoma;
      v. Gliosarcoma;
      vi. H3-mutated high-grade glioma;
      vii. High-grade astrocytoma with piloid features;
   b. Ampullary adenocarcinoma – intestinal type;
   c. Endometrial carcinoma;
   d. Intracranial and spinal ependymoma;
   e. Peritoneal mesothelioma;
   f. Pleural mesothelioma;
   g. Medulloblastoma;
   h. Meningioma;
   i. Metastatic spine tumors or brain metastases;
   j. Primary central nervous system lymphoma;
   k. Primary spinal cord tumors;
   l. Small bowel adenocarcinoma;
   m. Soft tissue sarcoma – solitary fibrous tumor or angiosarcoma;
   n. Vulvar cancer – adenocarcinoma or squamous cell carcinoma;
   o. Neurofibromatosis type 2 vestibular schwannomas with hearing loss;
   p. Vaginal cancer;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. For Alymsys, Avastin, Avzivi, Jobevne, or Vegzelma requests, member meets one of the following (a or b):
   a. Member must use Mvasi or Zirabev^, unless both are contraindicated or clinically significant adverse effects are experienced;
      ^Prior authorization may be required for Mvasi and Zirabev
   b. Request is for treatment associated with cancer for a State with regulations against step therapy in certain oncology settings *(see Appendix E*);

5. For ampullary adenocarcinoma, peritoneal mesothelioma, pleural mesothelioma, small bowel adenocarcinoma, or vulvar cancer: Prescribed as part of combination therapy;
6. For neurofibromatosis type 2 vestibular schwannomas with hearing loss: Prescribed as a single agent;
7. 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: 12 months

C. Oncology - Non-FDA-Approved Pediatric Indications (off-label) (must meet all)**:**
1. Diagnosis of one of the following (a or b):
   a. Diffuse high-grade glioma;
   b. Medulloblastoma;
2. Prescribed by or in consultation with an oncologist;
3. Age < 18 years;
4. For Alymsys, Avastin, Avzivi, Jobevne, or Vegzelma requests, member meets one of the following (a or b) member must use Mvasi or Zirabev^, unless both are contraindicated or clinically significant adverse effects are experienced;
   ^Prior authorization may be required for Mvasi and Zirabev
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: 12months

D. Ophthalmology - Non-FDA-Approved Indications (off-label) (must meet all)**:**
1. Diagnosis of one of the following conditions (a-h):
   a. Neovascular (wet) age-related macular degeneration (nAMD);
   b. Macular edema following retinal vein occlusion (RVO);
   c. Diabetic macular edema (DME);
   d. Diabetic retinopathy (DR);
   e. Neovascular glaucoma;
   f. Choroidal neovascularization (including but not limited to choroidal neovascularization associated with: angioid streaks, no known cause, inflammatory conditions, high pathologic myopia, or ocular histoplasmosis syndrome, trauma, retinal dystrophies, rubeosis iridis, pseudoxanthoma elasticum);
   g. Radiation retinopathy;
   h. Retinopathy of prematurity (ROP);
2. Prescribed by or in consultation with an ophthalmologist;
3. Request is for bevacizumab intravitreal solution;
   **Requests for IV formulations of Avastin, Alymsys, Avzivi, Jobevne, Mvasi, Vegzelma, and Zirabev will not be approved*
4. Request meets one of the following (a or b):
   a. Dose does not exceed 2.5 mg per 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: 12 months

E. Other diagnoses/indications (must meet all)**:**

1. For Alymsys, Avastin, Avzivi, Jobevne, or Vegzelma requests for non-ophthalmology uses, member must use Mvasi or Zirabev^, unless both are contraindicated or clinically significant adverse effects are experienced;
   ^Prior authorization may be required for Mvasi and Zirabev
2. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer toLA.PMN.255.
3. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 2 above does not apply, refer to the off-label use policy LA.PMN.53

II. Continued Therapy

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

1.

Currently receiving medication via Louisiana Healthcare Connections benefit or member has previously met initial approval criteria;

2. Documentation supports that member is currently receiving Alymsys, Avastin, Avzivi, Jobevne, Mvasi, Vegzelma, or Zirabev for a covered oncology indication listed in section I and has received this medication for at least 30 days;

3.Member is responding positively to therapy;

4. For Alymsys, Avastin, Avzivi, Jobevne, or Vegzelma requests for non-ophthalmology uses, member must use Mvasi or Zirabev^, unless both are contraindicated or clinically adverse effects are experienced;

^Prior authorization may be required for Mvasi and Zirabev

5. 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 (*see Appendix E for dose rounding guidelines*);

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: 6 months

B. Other diagnoses/indications (must meet 1 and either 2 or 3)**:**

1. For Alymsys, Avastin, Avzivi, Jobevne, or Vegzelma requests for non-ophthalmology uses, member must use Mvasi or Zirabev^, unless both are contraindicated or clinically significant adverse effects are experienced;*
   ^Prior authorization may be required for Mvasi and Zirabev
2. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255

3. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 2 above does not apply, refer to the off-label use policy LA.PMN.53

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 policy LA.PMN.53

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

5-FU: fluorouracil
CapeOX: capecitabine, oxaliplatin
CRC: colorectal cancer
DME: diabetic macular edema
DR: diabetic retinopathy
FDA: Food and Drug Administration
FOLFIRI: fluorouracil, leucovorin, irinotecan
FOLFIRINOX: fluorouracil, leucovorin, irinotecan, oxaliplatin
FOLFOX: fluorouracil, leucovorin, oxaliplatin
HCC: hepatocellular carcinoma
IDH: isocitrate dehydrogenase gene
IROX: irinotecan, oxaliplatin
nAMD: neovascular (wet) age-related macular degeneration
NCCN: National Comprehensive Cancer Network
NSCLC: non-small cell lung cancer
PD-L1: programmed death-ligand 1
RCC: renal cell carcinoma
ROP: retinopathy of prematurity
RVO: retinal vein occlusion

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 and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
HCC		
Examples of first-line systemic therapy: • Lenvima® (lenvatinib) • sorafenib (Nexavar®)	Varies	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

- 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 4% 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
840 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 CRC	5 mg/kg or 10 mg/kg IV every 2 weeks 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 bevacizumab product-containing regimen	15 mg/kg IV every 3 weeks or 10 mg/kg IV every 2 weeks
Non-squamous NSCLC	15 mg/kg IV infusion every 3 weeks with carboplatin/paclitaxel	15 mg/kg IV every 3 weeks
Recurrent glioblastoma	10 mg/kg IV every 2 weeks	10 mg/kg IV every 2 weeks
Metastatic RCC	10 mg/kg IV every 2 weeks with interferon alfa	10 mg/kg IV every 2 weeks

Persistent, recurrent, or metastatic cervical cancer	15 mg/kg IV every 3 weeks with paclitaxel and cisplatin or paclitaxel and topotecan	15 mg/kg IV every 3 weeks
Epithelial ovarian, fallopian tube, or primary peritoneal cancer	Stage III or IV disease following initial surgical resection 15 mg/kg IV every 3 weeks with carboplatin/paclitaxel for up to 6 cycles, followed by bevacizumab 15 mg/kg every 3 weeks as a single agent for a total of up to 22 cycles or until disease progression, whichever occurs earlier Platinum resistant 10 mg/kg IV every 2 weeks with weekly paclitaxel, pegylated liposomal doxorubicin, or topotecan 15 mg/kg IV every 3 weeks with topotecan Platinum sensitive 15 mg/kg IV every 3 weeks with carboplatin and paclitaxel (for 6 to 8 cycles) or with carboplatin and gemcitabine (for 6 to 10 cycles), followed by bevacizumab 15 mg/kg every 3 weeks as a single agent until disease progression	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, until disease progression or unacceptable toxicity	15 mg/kg IV every 3 weeks
nAMD†, DME†, macular edema secondary to RVO†, neovascular glaucoma†	1.25 mg administered by intravitreal injection every 4 weeks	2.5 mg/dose
DR†, choroidal neovascularization†, radiation retinopathy†	1.25 mg administered by intravitreal injection	2.5 mg/dose
ROP†	0.2 mg administered by intravitreal injection	2.5 mg/dose

†Off-label

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.; September 2022. Available at: www.avastin.com. Accessed July 30, 2025.
2. Mvasi Prescribing Information. Thousand Oaks, CA: Amgen Inc.; June 2025. Available at: https://www.mvasi.com/hcp. Accessed July 30, 2025.
3. Zirabev Prescribing Information. New York, NY: Pfizer Inc.; August 2024. Available at: https://zirabev.pfizerpro.com. Accessed July 30, 2025.

4. Alymsys Prescribing Information. Bridgewater, NJ: Amneal Pharmaceuticals, LLC; April 2022. Available at https://www.accessdata.fda.gov/drugsatfda_docs/label/2022/761231s000lbl.pdf. Accessed July 14, 2025.
5. Vegzelma Prescribing Information. Incheon, Republic of Korea: Celltrion; February 2023. Available at: https://www.vegzelma.com. Accessed July 30, 2025.
6. Avzivi Prescribing Information. Guangzhou, Guangdong Province, China: Bio-Thera Solutions, Ltd.; December 2023. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/761198s000lbl.pdf. Accessed July 30, 2025.
7. Jobevne Prescribing Information. Cambridge, MA: Biocon Biologics; April 2025. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761175s000lbl.pdf. Accessed July 30, 2025.

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8. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed July 29, 2025.
9. National Comprehensive Cancer Network. Central Nervous System Cancers Version 1.2025. Available at: https://www.nccn.org/professionals/physician_gls/pdf/cns.pdf. Accessed July 29, 2025.
10. National Comprehensive Cancer Network. Ovarian Cancer Version 3.2025. Available at: https://www.nccn.org/professionals/physician_gls/pdf/ovarian.pdf. Accessed July 29, 2025.
11. National Comprehensive Cancer Network. Cervical Cancer Version 4.2025. Available at: https://www.nccn.org/professionals/physician_gls/pdf/cervical.pdf. Accessed July 29, 2025.
12. National Comprehensive Cancer Network. Hepatocellular Carcinoma Version 1.2025. Available at: https://www.nccn.org/professionals/physician_gls/pdf/hcc.pdf. Accessed July 30, 2025.
13. National Comprehensive Cancer Network. Kidney Cancer Version 1.2026. Available at: https://www.nccn.org/professionals/physician_gls/pdf/kidney.pdf. Accessed July 29, 2025.
14. National Comprehensive Cancer Network. Non-Small Cell Lung Cancer Version 7.2025. Available at: https://www.nccn.org/professionals/physician_gls/pdf/nscl.pdf. Accessed July 29, 2025.
15. Fahrenbruch R, Kintzel P, Bott AM., et al. Dose rounding of biologic and cytotoxic anticancer agents: a position statement of the hematology/oncology pharmacy association. Journal of Oncology Practice. 2018;14(3)e130-e136.

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16. American Academy of Ophthalmology Retina/Vitreous Panel. Preferred Practice Pattern® Guidelines. Age-Related Macular Degeneration. San Francisco, CA: American Academy of Ophthalmology; September 2024. Available at: https://www.aao.org/preferred-practice-pattern/age-related-macular-degeneration-ppp. Accessed July 30, 2025.
17. American Academy of Ophthalmology Retina/Vitreous Panel. Preferred Practice Pattern® Guidelines. Retinal Vein Occlusions. San Francisco, CA: American Academy of Ophthalmology; September 2024. Available at: https://www.aao.org/preferred-practice-pattern/ retinal-vein-occlusions-ppp. Accessed July 30, 2025.

18. American Academy of Ophthalmology Retina/Vitreous Panel. Preferred Practice Pattern® Guidelines. Diabetic Retinopathy. San Francisco, CA: American Academy of Ophthalmology; September 2024. Available at: https://www.aao.org/preferred-practice-pattern/diabetic-retinopathy-ppp. Accessed July 30, 2025.
19. Wen JC, Shah VA, Leng T, et al. Radiation retinopathy. American Academy of Ophthalmology EyeWiki. Available at: https://eyewiki.org/Radiation_Retinopathy. Last updated July 2, 2024. Accessed July 30, 2025.
20. Finger PT, Chin KJ, Semenova EA. Intravitreal anti-VEGF therapy for macular radiation retinopathy: a 10-year study. Eur J Ophthalmol. 2016; 26(1):60-66.
21. Shields CL, Dalvin LA, Chang M, et al. Visual outcome at 4 years following plaque radiotherapy and prophylactic intravitreal bevacizumab (every 4 months for 2 years) for uveal melanoma: Comparison with nonrandomized historical control individuals. JAMA Ophthalmol. 2020;138(2):136-146. doi:10.1001/jamaophthalmol.2019.5132.
22. De Ribot FM, Miller AM, Stevenson E, et al. Retinopathy of prematurity. American Academy of Ophthalmology EyeWiki. Available at: https://eyewiki.org/Retinopathy_of_Prematurity. Accessed July 30, 2025.
23. Mintz-Hittner HA, Kennedy KA, Chuang AZ, and the BEAT-ROP Cooperative Group. Efficacy of intravitreal bevacizumab for stage 3+ retinopathy of prematurity. N Engl J Med 2011;364:603-615. doi: 10.1056/NEJMoa1007374.
24. Sankar MJ, Sankar J, Chandra P. Anti-vascular endothelial growth factor (VEGF) drugs for treatment of retinopathy of prematurity. Cochrane Database Syst Rev 2018; 1:CD009734.
25. Modarres M, Naseripour M, Falavarjani KG, Nikeghbali A, Hashemi M, Parvaresh MM. Intravitreal injection of 2.5 mg versus 1.25 mg bevacizumab (Avastin) for treatment of CNV associated with AMD. Retina. 2009 Mar;29(3):319-24. doi:10.1097/IAE.0b013e318198148e.

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
C9257	Injection, bevacizumab, 0.25 mg
J9035	Injection, bevacizumab, 10 mg
J9999	Not otherwise classified, antineoplastic drugs
Q5107	Injection, bevacizumab-awwb, biosimilar, (Mvasi), 10 mg
Q5118	Injection, bevacizumab-bvcr, biosimilar, (Zirabev), 10 mg
Q5126	Injection, bevacizumab-maly, biosimilar, (Alymsys), 10 mg
Q5129	Injection, bevacizumab-adcd (Vegzelma), biosimilar, 10 mg
Q5160	Injection, bevacizumab-nwgd (jobevne), biosimilar, 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

ICD-10-CM Code	Description
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
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,	Type 2 diabetes mellitus with diabetic retinopathy with macular edema

ICD-10-CM Code	Description
E11.3311 – E11.3319, E11.3411 – E11.3419, E11.3511 – E11.3519	
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	LDH Approval Date
Converted corporate to local policy	01.21	04.21
FDA indication language updated for Zirabev to reflect expansion of indication to include epithelial ovarian, fallopian tube, or primary peritoneal cancer; amended language for ophthalmology non-FDA approved indications to be: request is for bevacizumab intravitreal solution; Applied redirection of Avastin to preferred biosimilars to other diagnoses/indications; Added additional NCCN-supported regimens and classifications for colorectal cancer, NSCLC, glioblastoma, cervical cancer, and epithelial ovarian, fallopian tube, or primary peritoneal cancer; added criterion that HCC be classified as Child-Pugh class A disease per NCCN; added low-grade WHO grade I glioma to NCCNsupported off-label indication; Updated with Mvasi's FDAapproved indications of epithelial ovarian, fallopian tube, or primary peritoneal cancers.	04.22	07.23.22
Added newly FDA-approved biosimilar Alymsys to policy; generalized language for oncology redirection bypass. Added additional NCCN-supported indications of ampullary adenocarcinoma cancer, malignant peritoneal mesothelioma, and pediatric diffuse high-grade glioma; re-classified anaplastic gliomas to astrocytoma and oligodendroglioma per updated NCCN classification; removed breast cancer indication, WHO grade 2 glioma indication, and single-agent therapy option for cervical cancer per NCCN; removed "radiographic and/or clinical relapse", "recurrent", and "carcinosarcoma with… BRCA 1/2 mutation" disease qualifiers for ovarian cancer as there are other clinical scenarios per NCCN; added new regimens for cervical and colorectal cancers per NCCN; references reviewed and updated. Template changes applied to other diagnoses/indications and continued therapy section. Added HCPCS codes C9142, Q5126, Q5129 Added Vegzelma biosimilar to policy. Added blurb this policy is for medical benefit only.	06.27.23	01.03.24
Annual review; per NCCN – for CRC added that disease is advanced, metastatic, or unresectable; for cervical cancer added option for single-agent therapy; for RCC removed combination therapy option with interferon alfa; for ovarian cancers simplified bevacizumab combination therapy criterion when used with a platinum and chemotherapy along with corresponding staging update to IB-IV disease, added combination therapy option with gemcitabine for platinum-resistant disease, and removed combination therapy with Zejula; for HCC added Child-Pugh class B option; clarified off-label indication of primary central nervous system cancer is specifically for lymphoma; modified low-grade (WHO Grade I) glioma to circumscribed glioma; revised mesotheliomas to remove "malignant"	05.07.24	07.29.24

Reviews, Revisions, and Approvals	Date	LDH Approval Date
per terminology change; references reviewed and updated; added newly FDA-approved biosimilar Avzivi to policy; for ovarian cancers, added combination therapy with Zejula per NCCN; created separate section for oncology – non-FDA-approved indications for pediatrics to include diffuse high-grade glioma.		
Removal of Appendix E, as LDH previously advised it is not applicable to Medicaid. Fe-organized FDA-approved indications for improved clarity; *for the following oncology indications, revised the following per NCCN*: for NSCLC, added qualifier of unresectable, specified sensitizing EGFR mutation for combination use with erlotinib, added additional agents with which pemetrexed and Tecentriq can be prescribed, removed requirement that the combination of carboplatin and paclitaxel is reserved for first-line treatment; for RCC, added qualifier of relapsed; for ovarian cancer, removed requirement that use with platinum agent + chemotherapy followed by single agent bevacizumab be limited to Stage IB-IV disease, added that combination with Zejula may be used for maintenance therapy if intolerant to Lynparza, added additional combination regimens for platinum-resistant disease (cyclophosphamide and Keytruda, Ixempra, Elahere), added combination with Elhere for platinum-sensitive disease; for HCC, removed requirement that disease is Child-Pugh class A or B and added pathway for adjuvant therapy in members at high risk of recurrence following resection or ablation; added additional off-label uses (pleomorphic xanthroastrocytoma, gliosarcoma, H3-mutated high-grade glioma, high-grade astrocytoma with piloid features, neurofibromatosis type 2 vestibular schwannomas with hearing loss, vaginal cancer); added requirement for combination use for ampullary adenocarcinoma, peritoneal mesothelioma, pleural mesothelioma, small bowel adenocarcinoma, or vulvar cancer; *for ophthalmology uses*: revised choroidal neovascularization to allow any cause and added additional examples, added radiation retinopathy and retinopathy of prematurity as supported by literature, added requirement for ophthalmologist prescriber, removed age restriction as some covered diagnoses may affect pediatric populations; references reviewed and updated.	01.15.25	04.07.25
Added newly FDA-approved biosimilar Jobevne to criteria; for cervical cancer, added Tecentriq as an option to combination therapy for paclitaxel/cisplatin and paclitaxel/carboplatin, and clarified topotecan is used with paclitaxel per NCCN; for HCC, removed option for use as adjuvant therapy following resection or ablation and member is at high risk for recurrence and added option for use as	06.17.25	11.06.25

Reviews, Revisions, and Approvals	Date	LDH Approval Date
subsequent-line systemic therapy if progression on or after systemic therapy per NCCN.		
Extended initial approval duration 6 months to 12 months for this maintenance medication for a chronic condition; *for the following oncology indications, revised the following per NCCN*: for epithelial ovarian, fallopian tube, and primary peritoneal cancer, added option for combination use in platinum-resistant persistent disease with carboplatin and paclitaxel, carboplatin and gemcitabine, or carboplatin and liposomal doxorubicin; added additional off-label use in primary spinal cord tumors; *for ophthalmology uses*, revised diabetic retinopathy to allow any cause and stage; references reviewed and updated. HCPCS code added [Q5160].	01.26.26	

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. LHCC 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.

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 LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. 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. LHCC 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 LHCC has no control or right of control. Providers are not agents or employees of LHCC.