

**NOTE:** Failure to respond within 36 business hours will result in a denial for lack of information.

## Avastin<sup>®</sup> (bevacizumab)



### Treatment Request (Physician to Complete)

Visit [www.wellmark.com](http://www.wellmark.com) for the Wellmark Drug List for current medication tier levels and updated PA Forms

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<b>Facsimile Transmittal Sheet</b>	Date: ___/___/___
To: <u>Wellmark Pharmacy Services</u>	From (Prescriber's Name): _____
Fax Number: <u>(866) 884-4345</u>	Prescriber's DEA Number: _____
Phone Number: <u>(800) 600-8065</u>	Prescriber's Phone Number: _____
Prescriber's Specialty: _____	Prescriber's Fax Number: _____
Prescriber's Office Address: _____	
Street	Suite # City State Zip
<b>Patient Name:</b> _____	
<b>Patient ID:</b> _____	<b>Patient DOB:</b> ___/___/___

Please answer the following questions and fax this form back to (866) 884-4345. All fields are REQUIRED.

1. Please provide the diagnosis this therapy has been prescribed for: \_\_\_\_\_

ICD-9 Code: \_\_\_\_\_

2. What is the prescriber's specialty? \_\_\_\_\_

3. Dose per injection: \_\_\_\_\_ mg Frequency of injection: \_\_\_\_\_ per \_\_\_\_\_

**Attach lab results and other documentation as necessary**

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient, you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received this fax in error, please immediately notify the sender by telephone and destroy this original fax message.