



**Florida
Health Care
Plans**



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TO: FHCP PROVIDERS
FROM: FHCP UTILIZATION MANAGEMENT DEPARTMENT
DATE: APRIL 20, 2011
SUBJECT: AVASTIN AND RITUXAN

Please be advised effective 5/1/2011, prior authorization will be required for Avastin or Rituxan for reimbursement. Coverage criteria listed below is based on FDA label and NCCN guidelines. For patients currently on either of these medications, please have your office submit a referral and supporting clinical documentation then forward onto referrals for clinical review. (i.e immunohistochemistry for Rituximab).

The number for the FHCP Central Referral Department is 386-238-3230 - Fax is 386-238-3253.

Avastin (Bevacizumab)- Avastin is an anti-VEGF monoclonal antibody used to treat metastatic, recurrent, or locally advanced cancers: **Off-Label use must be supported by NCCN guidelines evidence rating 2a or greater.** Avastin prior authorization will be granted based on the conditions below:

- Metastatic carcinoma of the colon or rectum when used in combination with intravenous 5-Fluorouracil based chemotherapy for first-line or second-line treatment and the dose is 5 to 10 mg/kg every 2 weeks
- Metastatic human epidermal growth factor receptor 2 (HER2)-negative breast cancer when used in combination with paclitaxel for the treatment of patients who have not received chemotherapy for metastatic HER2-negative breast cancer and the dose is either 10 mg/kg every 2 weeks or 15 mg/kg every 3 weeks
- Non-squamous non-small cell lung cancer in combination with carboplatin and paclitaxel for the first-line treatment of patients with unresectable, locally advanced, recurrent or metastatic non-squamous cell disease and the dose is up to 15 mg/kg every 3 weeks
- Central nervous system (CNS) cancers and the dose is up to 10 mg/kg every 2 weeks
- Renal cell carcinoma (RCC) and the dose is up to 10 mg/kg every 2 weeks.
- Ovarian cancer and the dose is up to 15 mg/kg every 3 weeks.
- Cervical cancer and the dose is up to 15 mg/kg every 3 weeks.
- Wet AMD, diabetic macular edema, macular retinal edema.

Rituxan (for Rheumatoid Arthritis) - Rituxan is a CD-20 targeted B-cell depleting biologic. Approval for malignancies include all FDA approved indications. Off-label use will be reviewed for compliance to NCCN guidelines and an evidence rating of 2a or greater. Approval for Rheumatoid Arthritis is based on the following:

- Patient has failed 2 or more Anti-TNF agents
- Coverage will be for 1000mg x 2 treatments separated by 2 weeks
- Retreatment will not be covered sooner than 24 weeks post initial infusion
- Medical history and studies are reviewed in Referrals.
- Patient must be on Methotrexate.

The FHCP Policy on Medications Requiring Prior Authorization is always available on the FHCP Website and also included in the FHCP Provider Handbook.

Please follow the easy steps listed below.

1. Go to www.fhcp.com
2. Select the Providers tab on the right side of the menu bar.
3. Under Quick Links on the left side, you will find the FHCP Prior Authorization Medication List.

If you have any questions in reference to this memo, please contact the FHCP Central Referral Department at 386 / 238-3230. Thank you.