

POLICY: Oncology (Injectable) – Bevacizumab Products Utilization Management Medical Policy

- Avastin[®] (bevacizumab for intravenous injection – Genentech, Inc.)
- Jobevne[™] (bevacizumab-nwgd intravenous infusion – Biocon)
- Vegzelma[™] (bevacizumab-adcd intravenous infusion – Celltrion)
- Zirabev[™] (bevacizumab-bvzr intravenous infusion – Pfizer)

EFFECTIVE DATE: 1/1/2021

LAST REVISION DATE: 02/26/2025; selected revision 08/20/2025 and 12/3/2025

COVERAGE CRITERIA FOR: All Aspirus Medicare Plans

SUMMARY OF EVIDENCE

Bevacizumab is a recombinant humanized monoclonal antibody that binds to and inhibits the biologic activity of human vascular endothelial growth factor (VEGF), a key mediator of angiogenesis.¹ Bevacizumab is indicated for the following uses:

- **Cervical cancer** in combination with paclitaxel and cisplatin OR paclitaxel and topotecan for persistent, recurrent, or metastatic disease.
- **Colorectal cancer**, metastatic:
 - In combination with intravenous fluorouracil-based chemotherapy for first- or second-line treatment.
 - In combination with fluoropyrimidine-irinotecan-based or fluoropyrimidine-oxaliplatin-based chemotherapy for second-line treatment in patients who have progressed on a first-line bevacizumab-containing regimen.

Limitation of use: Bevacizumab is not indicated for adjuvant treatment of colon cancer.

- **Glioblastoma**, for treatment of recurrent disease in adults.
- **Hepatocellular carcinoma**, in combination with Tecentriq[®] (atezolizumab intravenous infusion) for the treatment of unresectable or metastatic disease in patients who have not received prior systemic therapy.
- **Non-small cell lung cancer (NSCLC)**, for non-squamous disease, in combination with carboplatin and paclitaxel for first-line treatment of unresectable, locally advanced, recurrent, or metastatic disease.
- **Ovarian (epithelial), fallopian tube, or primary peritoneal cancer:**
 - Recurrent disease that is platinum-resistant in combination with paclitaxel, Doxil[®] (doxorubicin liposome intravenous infusion), or topotecan, in patients who received no more than two prior chemotherapy regimens.
 - Recurrent disease that is platinum-sensitive in combination with carboplatin and paclitaxel or in combination with carboplatin and gemcitabine, followed by bevacizumab as a single agent.
 - In combination with carboplatin and paclitaxel, followed by bevacizumab as a single agent, for stage III or IV disease in patients following initial surgical resection.
- **Renal cell carcinoma**, metastatic, in combination with interferon alfa.

Analysis of Evidence

The information provided in the summary of evidence is supported by labeled indications, CMS-approved compendia, published clinical literature, clinical practice guidelines, and/or applicable National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs). Refer to the Sources of Information section of this policy for additional information.

Policy Statement

Prior authorization is recommended for medical benefit coverage of bevacizumab in patients with conditions other than ophthalmic. The intent of this policy is to provide recommendations for uses other than ophthalmic conditions. Approval is recommended for those who meet the Criteria and Dosing for the listed indications. Extended approvals are allowed if the patient continues to meet the Criteria and Dosing. All approvals are provided for the duration noted below.

This policy incorporates Medicare coverage guidance as set forth in National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs), as well as in companion policy articles and other guidance applicable to the relevant service areas. These documents are cited in the Sources of Information section of this policy. In some cases, this guidance includes specific lists of HCPCS and ICD-10 codes to help inform the coverage determination process. The Articles that include specific lists for billing and coding purposes will be included in the Sources of Information section of this policy. However, to the extent that this policy cites such lists of HCPCS and ICD-10 codes, they should be used for reference purposes only. The presence of a specific HCPCS or ICD-10 code in a chart or companion article to an LCD is not by itself sufficient to approve coverage. Similarly, the absence of such a code does not necessarily mean that the applicable condition or diagnosis is excluded from coverage.

Note: Conditions for coverage outlined in this Medicare Advantage Medical Policy may be less restrictive than those found in applicable National Coverage Determinations, Local Coverage Determinations and/or Local Coverage Articles. Examples of situations where this clinical policy may be less restrictive include, but are not limited to, coverage of additional indications supported by CMS-approved compendia and the exclusion from this policy of additional coverage criteria requirements outlined in applicable National Coverage Determinations, Local Coverage Determinations and/or Local Coverage Articles.

Indications with a ^ below are referenced in both the corresponding Standard Medical Utilization Management Internal Policy AND applicable National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and/or Local Coverage Articles (LCAs). Coverage criteria for these indications may be internally developed and/or referenced in applicable NCDs, LCDs, and/or LCAs. For these indications, internally developed coverage criteria is denoted throughout the policy in the following manner: 1) IC-L (internal criteria supported by the labeled indication), 2) IC-COMP (internal criteria supported by CMS-approved compendia), 3) IC-ISGP (internal criteria intended to interpret or supplement general provisions outlined in applicable NCDs, LCDs, and/or LCAs), or 4) IC-EC (internal criteria intended to expand coverage beyond the coverage outlined in applicable NCDs, LCDs, and/or LCAs). For these indications, coverage criteria that is NOT denoted with one of the above indicators is referenced in applicable NCDs, LCDs, and/or LCAs. Additional information supporting the rationale for determination of internal coverage criteria can be found via the Sources of Information section.

Indications with a # below are referenced in the corresponding Standard Medical Utilization Management Internal Policy, but are NOT directly referenced in applicable National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and/or Local Coverage Articles (LCAs). Coverage criteria for these indications is internally developed. These indications and their respective coverage criteria represent expanded coverage beyond the coverage outlined in applicable NCDs, LCDs, and/or LCAs.

*Indications with a * below are supported and referenced in applicable National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and/or Local Coverage Articles (LCAs), but are NOT directly referenced in the corresponding Standard Medical Utilization Management Internal Policy. Coverage criteria for these indications is referenced in applicable NCDs, LCDs, and/or LCAs.*

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Avastin, Jobevne, Vegzelma and Zirabev is recommended for requests meeting both the preferred product step therapy requirements and indication requirements. **Note: Ophthalmic indications do not require a prior authorization.** See ICD-10 codes not requiring authorization below.

Preferred Product(s): Alymsys and Mvasi

Non-Preferred Products(s): Avastin, Jobevne, Vegzelma and Zirabev

Step Therapy Requirements:

Authorization for a non-preferred biologic product or biosimilar will be granted if the patient meets any one of the items listed below (A, B, C, D or E). Chart notes documenting the issue must be provided at time of request:

- A. The patient is *not* considered a new start to the non-preferred product (new start is defined as no use of the requested product in the previous 365 days) OR
- B. Allergic reaction to a specific inactive ingredient in all preferred biologic products or biosimilars OR
- C. Adverse reaction to a specific inactive ingredient in all preferred biologic products or biosimilars OR
- D. Therapeutic success while taking a non-preferred biologic product or biosimilar and therapeutic failure during an adequate trial of all preferred biologic products or biosimilars which allowed sufficient time for a positive treatment outcome documented by medical chart notes OR
- E. The patient has a diagnosis not included in the FDA-approved indications of all preferred products, but is included in the FDA-approved indications of the non-preferred product

Please note:

- Factors such as patient or prescriber preference or healthcare facility's or pharmacy's inability or unwillingness to order or stock the preferred product(s) will not be considered
- Common side effects to all products and infusion-related reactions are not considered documented allergic reactions to a preferred product as they would be expected with the innovator and biosimilar products.
- Generally, an adequate trial of a drug is considered to be three months or longer in order to allow time for efficacy to be established

FDA-Approved Indications

1. Cervical Cancer. [^] *eviCore*

Criteria. Approve for 1 year if the patient meets the following criteria (A and B):

A) Patient is \geq 18 years of age; ^{IC-COMP} AND

B) Patient meets ONE of the following (i or ii):

i. Patient has recurrent or metastatic cervical cancer; ^{IC-COMP} OR

ii. Patient has persistent, recurrent, or metastatic small cell neuroendocrine carcinoma of the cervix. ^{IC-COMP}

Dosing. Approve 15 mg per kg administered intravenously not more frequently than once every 3 weeks.

2. Colon, Rectal, or Appendiceal Cancer. [^] *eviCore*

Criteria. Approve for 1 year if the patient meets the following criteria (A, B and C):

A) Patient is \geq 18 years of age; ^{IC-COMP} AND

B) The patient has recurrent, advanced or metastatic colon, rectal, or appendiceal cancer; ^{IC-COMP} AND

C) The medication is used in combination with a chemotherapy regimen. ^{IC-COMP}

Note: Examples of chemotherapy are 5-fluorouracil with leucovorin, and may include one or both of oxaliplatin, irinotecan; capecitabine with or without oxaliplatin; irinotecan with or without oxaliplatin).

Dosing. Approve one of the following dosing regimens (A, B, or C):

A) 5 mg per kg administered intravenously not more frequently than once every 2 weeks; OR

B) 10 mg per kg administered intravenously not more frequently than once every 2 weeks; OR

C) 7.5 mg per kg administered intravenously not more frequently than once every 3 weeks.

3. Central Nervous System Tumors. [^] *eviCore*

Note: For pediatric patients see Pediatric Central Nervous System Tumors.

Criteria. Approve for 1 year if the patient meets the following criteria (A, B and C):

- A) Patient is ≥ 18 years of age; ^{IC-COMP} AND
- B) Patient has tried at least one previous therapy; ^{IC-COMP} AND
Note: Examples are temozolomide capsules or injection, etoposide, carmustine, radiotherapy.
- C) Patient has ONE of the following (i, ii, iii, iv, v, vi, vii, viii, or ix):
 - i. Anaplastic gliomas; ^{IC-COMP} OR
 - ii. Astrocytoma; ^{IC-COMP} OR
 - iii. Glioblastoma; ^{IC-COMP} OR
 - iv. Intracranial and spinal ependymoma (excluding subependymoma); ^{IC-COMP} OR
 - v. Meningiomas; ^{IC-COMP} OR
 - vi. Oligodendroglioma; ^{IC-COMP} OR
 - vii. Medulloblastoma; ^{IC-COMP} OR
 - viii. Neurofibromatosis type 2 vestibular schwannomas; ^{IC-COMP} OR
 - ix. Symptoms due to one of the following (a, b, or c):
 - 1. Radiation necrosis; ^{IC-COMP} OR
 - 2. Brain edema; ^{IC-COMP} OR
 - 3. Mass effect. ^{IC-COMP}

Dosing. Approve 10 mg per kg administered intravenously not more frequently than once every 2 weeks.

4. Hepatocellular Carcinoma. ^{eviCore}

Criteria. Approve for 1 year if the patient meets the following criteria (A, B, and C):

- A) Patient is ≥ 18 years of age; ^{IC-COMP} AND
- B) Patient meets ONE of the following (i or ii):
 - i. Approve for 1 year (total) if the patient meets ALL of the following (a, b, and c):
 - 1. Patient has undergone resection or ablation therapy; ^{IC-COMP} AND
 - 2. Patient is at high-risk of recurrence; ^{IC-COMP} AND
Note: High-risk is defined as size > 5 cm, > 3 tumors, macovascular invasion, microvessel invasion on histology, or grade 3/4 histology.
 - 3. Medication is used as adjuvant therapy; ^{IC-COMP} OR
 - ii. Approve for 1 year if the patient meets BOTH of the following (a and b):
 - 1. Medication is used for first-line therapy; ^{IC-COMP} AND
 - 2. According to the prescriber, the patient has ONE of the following [(1) or (2)]:
 - a. Liver-confined, unresectable disease and is deemed ineligible for transplant; ^{IC-COMP} OR
 - b. Extrahepatic/metastatic disease and is deemed ineligible for resection, transplant, or locoregional therapy; ^{IC-COMP} AND
- C) The medication is used in combination with Tecentriq (atezolizumab intravenous infusion). ^{IC-COMP}

Dosing. Approve 15 mg per kg administered intravenously not more frequently than once every 3 weeks.

5. Non-Small Cell Lung Cancer. [^] *eviCore*

Criteria. Approve for 1 year if the patient meets the following criteria (A, B, and C):

A) Patient is ≥ 18 years of age; ^{IC-COMP} AND

B) Patient does not have a history of recent hemoptysis; ^{IC-COMP} AND

C) Patient has recurrent, advanced, or metastatic non-squamous non-small cell lung cancer (NSCLC) and meets ONE of the following criteria (i, ii, iii, iv, or v): ^{IC-COMP}

Note: Non-squamous NSCLC includes adenocarcinoma, large cell, or NSCLC not otherwise specified.

i. The NSCLC tumor is negative or unknown for actionable mutations and the patient meets ONE of the following criteria (a, b, or c): ^{IC-COMP}

Note: Examples of actionable mutations include sensitizing epidermal growth factor receptor (*EGFR*) mutation, anaplastic lymphoma kinase (*ALK*) fusions, *RET* rearrangement positive, *MET* exon 14 skipping, *NTRK* gene fusion positive, *BRAF V600E* mutation positive, *NRG1*, and ROS proto-oncogene 1 (*ROS1*) rearrangement positive. The tumor may be *KRAS G12C* mutation positive.

a. The medication is used as initial therapy in combination with other systemic therapies; ^{IC-COMP} OR

Note: Examples of systemic therapies are cisplatin, carboplatin, Tecentriq (atezolizumab intravenous infusion), pemetrexed, paclitaxel.

b. The medication is used as continuation maintenance therapy and meets ONE of the following [(1), (2), or (3)]: ^{IC-COMP}

(1) The medication is used as a single agent; ^{IC-COMP} OR

(2) The medication is used in combination with Tecentriq, if Tecentriq was used in combination with bevacizumab for first-line therapy; ^{IC-COMP} OR

(3) The medication is used in combination with pemetrexed, if pemetrexed was used in combination with bevacizumab for first-line therapy; ^{IC-COMP}
OR

c. The medication is used as subsequent therapy in combination with other systemic therapies; ^{IC-COMP} OR

Note: Examples of systemic therapies are cisplatin, carboplatin, pemetrexed, paclitaxel.

ii. The tumor is positive for (*EGFR*) exon 19 deletion or exon 21 *L858R* mutations and the patient meets ONE of the following (a or b): ^{IC-COMP}

a. The medication is used as first-line or continuation maintenance therapy in combination with erlotinib; ^{IC-COMP} OR

b. The medication is used as subsequent therapy following prior targeted therapy; ^{IC-COMP} OR

Note: Examples of targeted therapy include Gilotrif (afatinib tablet), Tagrisso (osimertinib tablet), erlotinib, Iressa (gefitinib tablet), Vizimpro (dacomitinib tablet).

iii. Patient meets all of the following (a, b, and c):

a. The medication is used first-line; ^{IC-COMP} AND

b. The medication is used in combination with other systemic therapies; ^{IC-COMP}
AND

Note: Examples include carboplatin plus paclitaxel or pemetrexed; cisplatin plus pemetrexed; and Tecentriq plus carboplatin and paclitaxel.

- c. The tumor is positive for ONE of the following mutations [(1), (2), or (3)]:
1. *EGFR* exon 20 mutation; ^{IC-COMP} OR
 2. *ERBB2* (HER2) mutation; ^{IC-COMP} OR
 3. *NRG1* gene fusion; ^{IC-COMP} OR

iv. Patient meets all of the following (a, b, and c):

- a. The medication is used as first-line or subsequent therapy; ^{IC-COMP} AND
b. The medication is used in combination with other systemic therapies; ^{IC-COMP} AND

Note: Examples include carboplatin plus paclitaxel or pemetrexed; cisplatin plus pemetrexed; and Tecentriq plus carboplatin and paclitaxel.

- c. The tumor is positive for ONE of the following mutations [(1), (2), or (3)]:
1. *BRAF V600E* mutation; ^{IC-COMP} OR
 2. *NTRK1/2/3* gene fusion positive; ^{IC-COMP} OR
 3. *MET* exon 14 skipping mutation; ^{IC-COMP} OR

v. Patient meets all of the following (a, b, c, and d):

- a. The medication is used as subsequent therapy; ^{IC-COMP} AND
b. The medication is used in combination with other systemic therapies; ^{IC-COMP} AND

Note: Examples include carboplatin plus paclitaxel or pemetrexed; cisplatin plus pemetrexed; and Tecentriq plus carboplatin and paclitaxel.

- c. The tumor is positive for ONE of the following mutations [(1), (2), (3), or (4)]:
1. *EGFR S768I, L861Q*, and/or *G719X* mutation; ^{IC-COMP} OR
 2. *ALK* rearrangement positive; ^{IC-COMP} OR
 3. *ROS1* rearrangement positive; ^{IC-COMP} OR
 4. *RET* rearrangement; ^{IC-COMP} AND

- d. Patient has previously received targeted drug therapy for the specific mutation. ^{IC-COMP}

Note: Examples of targeted drug therapy include Gilotrif (afatinib tablets), Tagrisso (osimertinib tablets), erlotinib, Iressa (gefitinib tablets), Vizimpro (dacomitinib tablets), Xalkori (crizotinib capsules), Rozlytrek (entrectinib capsules), Zykadia (ceritinib tablets), Gavreto (pralsetinib capsules), Retevmo (selpercatinib capsules and tablets), and Cometriq (cabozantinib capsules and tablets).

Dosing. Approve 15 mg per kg administered intravenously not more frequently than once every 3 weeks.

6. Ovarian, Fallopian Tube, or Primary Peritoneal Cancer. ^{^ eviCore}

Criteria. Approve for 1 year if the patient is ≥ 18 years of age. ^{IC-COMP}

Dosing. Approve one of the following doses (A or B):

- A) Up to 15 mg per kg intravenous infusion not more frequently than once every 3 weeks; OR
- B) 10 mg per kg intravenous infusion not more frequently than once every 2 weeks.

7. Renal Cell Cancer. ^{^ eviCore}

Criteria. Approve for 1 year if the patient meets the following criteria (A and B):

- A) Patient is \geq 18 years of age; ^{IC-COMP} AND
- B) Patient has relapsed, metastatic, or Stage IV renal cell cancer. ^{IC-COMP}

Dosing. Approve 10 mg per kg administered intravenously not more frequently than once every 2 weeks.¹

Other Uses with Supportive Evidence

8. Ampullary Adenocarcinoma. ^{^ eviCore}

Criteria. Approve for 1 year if the patient meets the following criteria (A, B, and C):

- A) Patient is \geq 18 years of age; ^{IC-COMP} AND
- B) Patient has intestinal type disease; ^{IC-COMP} AND
- C) The medication is used in combination with chemotherapy. ^{IC-COMP}

Note: Examples of chemotherapy include FOLFOX (leucovorin, fluorouracil, oxaliplatin), FOLFIRI (leucovorin, fluorouracil, irinotecan), FOLFIRINOX (leucovorin, fluorouracil, oxaliplatin, irinotecan), and CapeOX (capecitabine, oxaliplatin).

Dosing. Approve 7.5 mg/kg administered intravenously not more frequently than once every 3 weeks.

9. Endometrial Carcinoma. ^{^ eviCore}

Criteria. Approve for 1 year if the patient meets the following criteria (A and B):

- A) Patient is \geq 18 years of age; ^{IC-COMP} AND
- B) The patient has recurrent, advanced, or metastatic disease. ^{IC-COMP}

Dosing. Approve up to 15 mg/kg administered intravenously not more frequently than once every 3 weeks.

10. Mesothelioma. ^{^ eviCore}

Criteria. Approve for 1 year if the patient meets the following criteria (A, B, and C):

- A) Patient is \geq 18 years of age; ^{IC-COMP} AND
- B) The patient has one of the following (i, ii, iii, or iv):
 - i. Pleural mesothelioma; ^{IC-COMP} OR

- ii. Peritoneal mesothelioma;^{IC-COMP} OR
 - iii. Pericardial mesothelioma;^{IC-COMP} OR
 - iv. Tunica vaginalis testis mesothelioma;^{IC-COMP} AND
- C) Patient meets ONE of the following (i or ii):
- i. Bevacizumab will be used in combination with a chemotherapy regimen;^{IC-COMP} OR
Note: Examples of chemotherapy are pemetrexed, cisplatin, carboplatin.
 - ii. Bevacizumab will be used in combination with Tecentriq (atezolizumab intravenous infusion).^{IC-COMP}

Dosing. Approve 15 mg per kg administered intravenously not more frequently than once every 3 weeks.

11. Pediatric Central Nervous System Tumors. [^] *eviCore*

Criteria. Approve for 1 year if the patient meets the following criteria (A, B and C):

- A) Patient is < 18 years of age;^{IC-COMP} AND
- B) Patient has ONE of the following (i or ii):
 - i. Patient has pediatric-type diffuse high-grade glioma;^{IC-COMP} OR
Note: Examples include diffuse hemispheric glioma, diffuse pediatric-type high-grade glioma, infant-type hemispheric glioma, and diffuse midline glioma.
 - ii. Pediatric medulloblastoma;^{IC-COMP} AND
- C) Patient has recurrent or progressive disease.^{IC-COMP}

Dosing. Approve 10 mg/kg administered intravenously not more frequently than once every 2 weeks.

12. Small Bowel Adenocarcinoma. [^] *eviCore*

Criteria. Approve for 1 year if the patient meets the following criteria (A, B, and C):

- A) Patient is ≥ 18 years of age;^{IC-COMP} AND
- B) Patient has advanced or metastatic disease;^{IC-COMP} AND
- C) The medication is used in combination with chemotherapy.^{IC-COMP}
Note: Examples of chemotherapy are fluorouracil, leucovorin, and oxaliplatin (FOLFOX), capecitabine and oxaliplatin (CapeOX), fluorouracil, leucovorin, oxaliplatin, and irinotecan (FOLFIRINOX).

Dosing. Approve up to 7.5 mg/kg administered intravenously not more frequently than once every 2 weeks.

13. Soft Tissue Sarcoma. [^] *eviCore*

Criteria. Approve for 1 year if the patient meets BOTH of the following criteria (A and B):

- A) Patient is ≥ 18 years of age; ^{IC-COMP} AND
- B) Patient has angiosarcoma or solitary fibrous tumor. ^{IC-COMP}

Dosing. Approve up to 15 mg/kg administered intravenously not more frequently than once every 2 weeks.

14. Vaginal Cancer. ^{^ eviCore}

Criteria. Approve for 1 year if the patient meets ALL of the following (A and B):

- A) Patient is ≥ 18 years of age; ^{IC-COMP} AND
- B) Patient has advanced, recurrent, or metastatic disease. ^{IC-COMP}

Dosing. Approve 15 mg/kg administered intravenously not more frequently than once every 3 weeks.

15. Vulvar Cancer. ^{^ eviCore}

Criteria. Approve for 1 year if the patient meets the following criteria (A and B):

- A) Patient is ≥ 18 years of age; ^{IC-COMP} AND
- B) Patient has advanced, recurrent, or metastatic disease. ^{IC-COMP}

Dosing. Approve 15 mg/kg administered intravenously not more frequently than once every 3 weeks.

16. Hereditary Hemorrhagic Telangiectasia (HHT) with Arteriovenous Malformations (AVMs). [#]

Criteria. Approve for 1 year.

Dosing. Approve the requested dose.

I. Coverage of **Avastin** is recommended in patients who meet the following criteria:

Other Uses with Supportive Evidence

1. **Neovascular or Vascular Ophthalmic Conditions.** [^]

Note: Examples of neovascular or vascular ophthalmic conditions include diabetic macular edema (includes patients with diabetic retinopathy and diabetic macular edema), macular edema following retinal vein occlusion, myopic choroidal neovascularization, neovascular (wet) age-related macular degeneration, other neovascular diseases of the eye (e.g., neovascular glaucoma, retinopathy of prematurity, sickle cell neovascularization, choroidal neovascular conditions).

Criteria. Approve for 3 years.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of bevacizumab products is not recommended in the following situations:

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

ICD-10 CODES NOT REQUIRING AUTHORIZATION

Avastin will require an authorization for any submitted ICD-10 code except for the following.

ICD-10 CODE	DESCRIPTION
E08.311	Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy with macular edema
E08.3211	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, right eye
E08.3212	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, left eye
E08.3213	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, bilateral
E08.3311	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema, right eye
E08.3312	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema, left eye
E08.3313	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
E08.3411	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, right eye
E08.3412	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, left eye
E08.3413	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, bilateral
E08.3511	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, right eye
E08.3512	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, left eye
E08.3513	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, bilateral
E08.3521	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye

ICD-10 CODE	DESCRIPTION
E08.3522	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
E08.3523	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E08.3531	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
E08.3532	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
E08.3533	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral
E08.3541	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye
E08.3542	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
E08.3543	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral
E08.3551	Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, right eye
E08.3552	Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, left eye
E08.3553	Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, bilateral
E08.3591	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, right eye
E08.3592	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, left eye
E08.3593	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, bilateral
E09.311	Drug or chemical induced diabetes mellitus with unspecified diabetic retinopathy with macular edema
E09.3211	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye
E09.3212	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye
E09.3213	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral

ICD-10 CODE	DESCRIPTION
E09.3311	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye
E09.3312	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye
E09.3313	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
E09.3411	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye
E09.3412	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye
E09.3413	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral
E09.3511	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye
E09.3512	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye
E09.3513	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral
E09.3521	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
E09.3522	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
E09.3523	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E09.3531	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
E09.3532	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
E09.3533	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral
E09.3541	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye
E09.3542	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
E09.3543	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral

ICD-10 CODE	DESCRIPTION
E09.3551	Drug or chemical induced diabetes mellitus with stable proliferative diabetic retinopathy, right eye
E09.3552	Drug or chemical induced diabetes mellitus with stable proliferative diabetic retinopathy, left eye
E09.3553	Drug or chemical induced diabetes mellitus with stable proliferative diabetic retinopathy, bilateral
E09.3591	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye
E09.3592	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye
E09.3593	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral
E10.311	Type 1 diabetes mellitus with unspecified diabetic retinopathy with macular edema
E10.3211	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye
E10.3212	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye
E10.3213	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral
E10.3311	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye
E10.3312	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye
E10.3313	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
E10.3411	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye
E10.3412	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye
E10.3413	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral
E10.3511	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye
E10.3512	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye
E10.3513	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral

ICD-10 CODE	DESCRIPTION
E10.3521	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
E10.3522	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
E10.3523	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E10.3531	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
E10.3532	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
E10.3533	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral
E10.3541	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye
E10.3542	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
E10.3543	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral
E10.3551	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, right eye
E10.3552	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, left eye
E10.3553	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, bilateral
E10.3591	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye
E10.3592	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye
E10.3593	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral
E11.A	Type 2 diabetes mellitus without complications in remission
E11.311	Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema
E11.3211	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye
E11.3212	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye
E11.3213	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral

ICD-10 CODE	DESCRIPTION
E11.3311	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye
E11.3312	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye
E11.3313	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
E11.3411	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye
E11.3412	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye
E11.3413	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral
E11.3511	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye
E11.3512	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye
E11.3513	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral
E11.3521	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
E11.3522	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
E11.3523	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E11.3531	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
E11.3532	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
E11.3533	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral
E11.3541	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye
E11.3542	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
E11.3543	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral
E11.3551	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, right eye

ICD-10 CODE	DESCRIPTION
E11.3552	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, left eye
E11.3553	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, bilateral
E11.3591	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye
E11.3592	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye
E11.3593	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral
E13.311	Other specified diabetes mellitus with unspecified diabetic retinopathy with macular edema
E13.3211	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye
E13.3212	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye
E13.3213	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral
E13.3311	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye
E13.3312	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye
E13.3313	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
E13.3411	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye
E13.3412	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye
E13.3413	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral
E13.3511	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye
E13.3512	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye
E13.3513	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral
E13.3521	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye

ICD-10 CODE	DESCRIPTION
E13.3522	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
E13.3523	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E13.3531	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
E13.3532	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
E13.3533	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral
E13.3541	Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye
E13.3542	Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
E13.3543	Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral
E13.3551	Other specified diabetes mellitus with stable proliferative diabetic retinopathy, right eye
E13.3552	Other specified diabetes mellitus with stable proliferative diabetic retinopathy, left eye
E13.3553	Other specified diabetes mellitus with stable proliferative diabetic retinopathy, bilateral
E13.3591	Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye
E13.3592	Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye
E13.3593	Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral
H21.1X1	Other vascular disorders of iris and ciliary body, right eye
H21.1X2	Other vascular disorders of iris and ciliary body, left eye
H21.1X3	Other vascular disorders of iris and ciliary body, bilateral
H21.1X9	Other vascular disorders of iris and ciliary body, unspecified eye
H34.8110	Central retinal vein occlusion, right eye, with macular edema
H34.8111	Central retinal vein occlusion, right eye, with retinal neovascularization
H34.8112	Central retinal vein occlusion, right eye, stable
H34.8120	Central retinal vein occlusion, left eye, with macular edema

ICD-10 CODE	DESCRIPTION
H34.8121	Central retinal vein occlusion, left eye, with retinal neovascularization
H34.8122	Central retinal vein occlusion, left eye, stable
H34.8130	Central retinal vein occlusion, bilateral, with macular edema
H34.8131	Central retinal vein occlusion, bilateral, with retinal neovascularization
H34.8132	Central retinal vein occlusion, bilateral, stable
H34.8310	Tributary (branch) retinal vein occlusion, right eye, with macular edema
H34.8311	Tributary (branch) retinal vein occlusion, right eye, with retinal neovascularization
H34.8312	Tributary (branch) retinal vein occlusion, right eye, stable
H34.8320	Tributary (branch) retinal vein occlusion, left eye, with macular edema
H34.8321	Tributary (branch) retinal vein occlusion, left eye, with retinal neovascularization
H34.8322	Tributary (branch) retinal vein occlusion, left eye, stable
H34.8330	Tributary (branch) retinal vein occlusion, bilateral, with macular edema
H34.8331	Tributary (branch) retinal vein occlusion, bilateral, with retinal neovascularization
H34.8332	Tributary (branch) retinal vein occlusion, bilateral, stable
H35.051	Retinal neovascularization, unspecified, right eye
H35.052	Retinal neovascularization, unspecified, left eye
H35.053	Retinal neovascularization, unspecified, bilateral
H35.059	Retinal neovascularization, unspecified, unspecified eye
H35.3210	Exudative age-related macular degeneration, right eye, stage unspecified
H35.3211	Exudative age-related macular degeneration, right eye, with active choroidal neovascularization
H35.3212	Exudative age-related macular degeneration, right eye, with inactive choroidal neovascularization
H35.3213	Exudative age-related macular degeneration, right eye, with inactive scar
H35.3220	Exudative age-related macular degeneration, left eye, stage unspecified
H35.3221	Exudative age-related macular degeneration, left eye, with active choroidal neovascularization
H35.3222	Exudative age-related macular degeneration, left eye, with inactive choroidal neovascularization

ICD-10 CODE	DESCRIPTION
H35.3223	Exudative age-related macular degeneration, left eye, with inactive scar
H35.3230	Exudative age-related macular degeneration, bilateral, stage unspecified
H35.3231	Exudative age-related macular degeneration, bilateral, with active choroidal neovascularization
H35.3232	Exudative age-related macular degeneration, bilateral, with inactive choroidal neovascularization
H35.3233	Exudative age-related macular degeneration, bilateral, with inactive scar
H35.351	Cystoid macular degeneration, right eye
H35.352	Cystoid macular degeneration, left eye
H35.353	Cystoid macular degeneration, bilateral
H35.359	Cystoid macular degeneration, unspecified eye
H35.81	Retinal edema
H40.841	Neovascular secondary angle closure glaucoma, right eye
H40.842	Neovascular secondary angle closure glaucoma, left eye
H40.843	Neovascular secondary angle closure glaucoma, bilateral
H40.849	Neovascular secondary angle closure glaucoma, unspecified eye
H40.89	Other specified glaucoma
H44.2A1	Degenerative myopia with choroidal neovascularization, right eye
H44.2A2	Degenerative myopia with choroidal neovascularization, left eye
H44.2A3	Degenerative myopia with choroidal neovascularization, bilateral eye

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HISTORY

Type of Revision	Summary of Changes	Date
Policy created	New Medicare Advantage Medical Policy	11/14/18
Policy revision	Reviewed and revised original policy created 11/14/2018 in accordance with Local Coverage Article A52370	10/9/2019
Policy revision	Reviewed and revised original policy created 11/14/2018 in accordance with Local Coverage Article A52370	11/6/2019
Policy revision	Completion of 2019 monthly monitoring process in accordance with Local Coverage Determination L33394, Local Coverage Article A52370	11/29/2019
Policy revision	Non-clinical update to policy to add the statement “This policy incorporates Medicare coverage guidance as set forth in National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs), as well as in companion policy articles and other guidance applicable to the relevant service areas. These documents are cited in the References section of this policy. In some cases, this guidance includes specific lists of HCPCS and ICD-10 codes to help inform the coverage determination process. The Articles that include specific lists for billing and coding purposes will be included in the Reference section of this policy. However, to the extent that this policy cites such lists of HCPCS and ICD-10 codes, they should be used for reference purposes only. The presence of a specific HCPCS or ICD-10 code in a chart or companion article to an LCD is not by itself sufficient to approve coverage. Similarly, the absence of such a code does <u>not</u> necessarily mean that the applicable condition or diagnosis is excluded from coverage.”	1/30/2020
Policy revision	<ul style="list-style-type: none"> • Non-Small Cell Lung Cancer. Added new criteria for bevacizumab use in EGFR mutation-positive NSCLC in combination with erlotinib in first-line setting. • Vulvar Cancer. Changed dosing wording to state “not more frequently than once every 2 weeks.” 	4/2/2020
Policy revision	<ul style="list-style-type: none"> • Added following note: <u>Note:</u> Conditions for coverage outlined in this Medicare Advantage Medical Policy may be less restrictive than those found in applicable National Coverage Determinations, Local Coverage Determinations and/or Local Coverage Articles. Examples of situations where this clinical policy may be less restrictive include, but are not limited to, coverage of additional indications supported by CMS-approved compendia and the exclusion from this policy of additional coverage criteria requirements outlined in applicable National Coverage Determinations, Local Coverage Determinations and/or Local Coverage Articles. • Added new FDA-approval indication for hepatocellular carcinoma. For Dosing, added “not more frequently” for interval durations in all conditions. 	07/01/2020
Policy revision	<ul style="list-style-type: none"> • Central Nervous System Tumors: Moved the subtypes of tumors from indication to criteria. Changed patient has tried “one other therapy” to “one previous therapy”. Added carmustine and etoposide to existing examples in Note. For Intracranial and spinal ependymoma subtype, deleted reference to “adults” and instead added “in patients ≥ 18 years of age”. • Non-Small Cell Lung Cancer: Changed “targetable” mutations to “actionable” mutations. For bevacizumab use in combination with erlotinib, deleted criteria requiring “as first-line therapy”. Modified criteria requiring use of at least one targeted therapy (if positive for actionable mutation), to state “patient has previously received targeted drug therapy for an actionable mutations”. 	03/31/2021

	<p>Moved actionable mutations to list as examples in a new Note and added new actionable mutations <i>RET</i> rearrangement positive, <i>MET</i> exon 14 skipping, <i>NTRK</i> gene fusion positive, <i>BRAF V600E</i> mutation positive to the list. Deleted criteria referring to NSCLC tumor that is <i>BRAF V600E</i> mutation-positive and bevacizumab use as either first-line or subsequent therapy. This is not needed due to the modified criteria regarding targeted drug therapy for actionable mutation. For criteria referring to negative or unknown actionable mutations, moved examples to new Note and updated the list of actionable mutations as above. Previous criteria referring to bevacizumab use specifically in combination with “platinum therapies” was deleted and instead criteria was modified to say “with other systemic therapies”. A new Note has been added with examples of systemic therapies. For the other criteria referring to bevacizumab use as subsequent therapy, the criteria referring to “and is used as a single agent or in combination with other agents” was moved to a new Note.</p> <ul style="list-style-type: none"> • Soft Tissue Sarcoma: Moved the subtypes angiosarcoma and solitary fibrous tumor from indication to criteria. Deleted reference to hemangiopericytoma since it is no longer in guidelines. 	
Policy revision	<ul style="list-style-type: none"> • Neovascular or Vascular Ophthalmic Conditions – updated to specify that only Avastin is covered for this indication 	12/15/2021
Policy revision	<p>Central Nervous System Tumors: Added “Symptoms due to radiation necrosis, poorly controlled vasogenic edema, or mass effect” as additional options for approval.</p> <p>Colon or Rectal Cancer: Added “recurrent” as additional descriptor in “Patient has recurrent, advanced, or metastatic colon or rectal cancer.” Removed requirement that bevacizumab is not used for adjuvant treatment of colon cancer.</p> <p>Non-Small Cell Lung Cancer (NSCLC): Added “recurrent” as additional descriptor in “Patient has recurrent, advanced, or metastatic non-squamous cell NSCLC. Added “exon 19 deletion or L858R’ as additional descriptor to “NSCLC tumor is positive for epidermal growth factor receptor (EGFR) exon 19 deletion or L858R mutations.” Added tumor is positive for one of the following mutations: EGFR exon 20 mutation, KRAS G12C mutation, BRAF V600E, NTRK1/2/3 gene fusion, MET exon 14 skipping mutation, and RET rearrangement; and bevacizumab is used in combination other systemic therapies. Added Note with list of examples of systemic therapies.</p> <p>Breast Cancer: Removed breast cancer from Other Uses with Supportive Evidence due to National Comprehensive Cancer Network withdrawing its recommendations for bevacizumab for the treatment of breast cancer.</p> <p>Endometrial Cancer: Removed requirement that the patient has progressed on prior chemotherapy and added requirement that the patient has recurrent, advanced, or metastatic disease.</p> <p>Mesothelioma: Removed Malignant Pleural from the condition of approval. Added malignant peritoneal mesothelioma, pericardial mesothelioma, and tunica vaginalis testis mesothelioma as additional options for approval. Added “bevacizumab will be used in combination with Tecentriq” as an additional option for approval.</p>	03/18/2022
Aspirus Custom revision	Added the new biosimilar bevacizumab product, Alymsys, as a non-preferred biosimilar product requiring step through at least one preferred biosimilar agent for new starts only.	06/03/2022

Selected Revision	Product: Added Vegzelma to the list of bevacizumab products.	12/28/2022
Policy revision	<p>Hepatocellular Carcinoma: Remove requirement that the patient has unresectable or metastatic hepatocellular carcinoma or according to the prescriber, the patient is not a surgical candidate. Added “or B” to requirement that the patient has Child-Pugh Class A or B disease. Added requirement that the patient has unresectable disease and is not a transplant candidate; OR has liver-confined disease, inoperable by performance status, comorbidity, or with minimal or uncertain extrahepatic disease; OR has metastatic disease or extensive liver tumor burden.</p> <p>Non-Small Cell Lung Cancer: Added <i>KRAS G12C</i> is not considered an actionable mutation (the tumor may be <i>KRAS G12C</i> mutation positive) to requirement that the patient is negative or unknown for actionable mutations. Removed <i>KRAS G12C</i> mutation from requirement that the tumor is positive for one of the following mutations for first-line use.</p> <p>Mesothelioma: Removed “malignant” from malignant pleural mesothelioma and malignant peritoneal mesothelioma.</p> <p>Pediatric Central Nervous System Tumors: Added pediatric medulloblastoma as an option for approval. Removed requirement that the medication is used for palliation.</p>	04/16/2024
Aspirus P&T Review	Policy reviewed and approved by Aspirus P&T committee. Annual review process	09/16/2024
Aspirus Revision	Aspirus adding Alymsys as a preferred product due to Zirabev drug shortage. Alymsys will no longer require review.	10/9/2024
Policy revision	<p>Central Nervous System Tumors: Medulloblastoma and neurofibromatosis type 2 vestibular schwannomas added as new options for approval. Removed poorly control vasogenic from brain edema option for approval.</p> <p>Hepatocellular Carcinoma: Changed approval duration from 1 year to duration noted. Patient has Child-Pugh Class A or B disease and patient has not received prior systemic therapy were removed as requirements. Added new option for approval for 1 year (total), if patient has undergone resection or ablation therapy, patient is at high-risk of recurrence, and medication is used as adjuvant therapy. Added option for approval for 1 year if the medication is used for first-line therapy and the patient has liver-confined, unresectable disease and is deemed ineligible for transplant or the patient has extrahepatic/metastatic disease and is deemed ineligible for resection, transplant, or locoregional therapy. Removed liver-confined disease, inoperable by performance status, comorbidity, or with minimal or uncertain extrahepatic disease as an option for approval.</p> <p>Non-Small Cell Lung Cancer: Added <i>NRG1</i> and removed <i>KRAS G12C</i> is not considered an actionable mutation from the Note with examples of actionable mutations. Added <i>NRG1</i> as an option of approval for first-line use. Removed <i>RET</i> rearrangement as an option for approval for first-line or subsequent therapy. Added <i>RET</i> rearrangement as an option for approval for subsequent therapy and added additional targeted drug therapies to the Note.</p> <p>Vaginal Cancer: Added new condition of approval.</p> <p>Vulvar Cancer: Removed bevacizumab is used in combination with a chemotherapy regimen as a requirement.</p> <p>Formatting and notation updates. Revision based on commercial policy criteria changes.</p>	03/06/2025

Aspirus Update	Updated step therapy criteria to require clinical need for non-preferred product over the preferred products including chart note documentation to support the need for a non-preferred product.	05/08/2025
Policy revision	Added coverage for Hereditary Hemorrhagic Telangiectasia (HHT) with Arteriovenous Malformations (AVMs) per LCD L33394 update.	09/10/2025
Aspirus P&T Review	Policy reviewed and approved by Aspirus P&T committee. Annual review process	09/15/2025
Policy revision	Jobevne (bevacizumab-nwgd) was added to the policy; the same criteria apply as the other bevacizumab products.	09/22/2025
Aspirus Revision	Added ICD 10 codes H40.841, H40.842 and H40.843 to the section ICD-10 CODES NOT REQUIRING AUTHORIZATION per LCD Billing and Coding: Bevacizumab and biosimilars –L33394 (A52370) – Revision History Date 10/1/2025.	10/2/2025
Aspirus Revision	Added ICD 10 codes E11.A and H40.849 to the section ICD-10 CODES NOT REQUIRING AUTHORIZATION per LCD Billing and Coding: Bevacizumab and biosimilars –L33394 (A52370) – Revision History Date 10/1/2025.	10/2/2025
Aspirus Update	Updated preferred products to remove Zirabev effective 1/1/26.	12/3/2025