

Medicare Advantage Medical Utilization Review Policy

Policy:	Oncology (Injectable) – Bevacizumab Products Utilization Management Medical Policy • Avastin[®] (bevacizumab intravenous infusion – Genentech) • Alynysys[®] (bevacizumab-maly intravenous infusion – Amneal) • Jobevne[™] (bevacizumab-nwgd intravenous infusion – Biocon) • Mvasi[™] (bevacizumab-awwb intravenous infusion – Amgen) • Vegzelma[™] (bevacizumab-adcd intravenous infusion – Celltrion) • Zirabev[™] (bevacizumab-bvzr intravenous infusion – Pfizer)
Date:	03/24/2026
Applicable Lines of Business:	Medicare Advantage - Medical
Applicable States:	CGS J15 – Ohio, Kentucky FCSO JN – Florida, Puerto Rico, Virgin Islands Noridian JE: California, American Samoa, Guam, Hawaii, Northern Mariana Islands, Nevada Noridian JF: Alaska, Idaho, Oregon, Washington, Arizona, Montana, North Dakota, South Dakota, Utah, Wyoming Novitas JH – Colorado, New Mexico, Oklahoma, Texas, Arkansas, Louisiana, Mississippi Novitas JL – Delaware, District of Columbia, Maryland, New Jersey, Pennsylvania, Massachusetts, Maine, New Hampshire, Rhode Island, Vermont Palmetto, JJ: Alabama, Georgia, Tennessee Palmetto, JM: North Carolina, South Carolina, Virginia, West Virginia WPS J5 – Iowa, Kansas, Missouri, Nebraska WPS J8 – Indiana, Michigan
Applicable NCDs, LCDs, and/or LCAs	None*

* Policy developed in alignment with CMS Memo: Off-label Use of Drugs in Medicare Advantage Step Therapy Programs. See Sources of Information.

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. 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. Requests for doses outside of the established dosing document in this policy will be considered on a case-by-case basis by a clinician (i.e., Medical Director or Pharmacist). All approvals are provided for the duration noted below. Because of the specialized skills required for evaluation and diagnosis of patients treated with bevacizumab as well as the monitoring required for adverse events and long-term efficacy, approval requires bevacizumab to be prescribed by or in consultation with a physician who specializes in the condition being treated.

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.

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA

I. Coverage of **Avastin, Alymsys, Jobevne, Mvasi, Vegzelma and Zirabey** is recommended in patients who meet the following criteria:

FDA-Approved Indications

1. Central Nervous System Tumors. @

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

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

A) Patient is ≥ 18 years of age; AND

B) Patient has tried at least one previous therapy; 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; OR
 - ii. Astrocytoma; OR
 - iii. Glioblastoma; OR
 - iv. Intracranial and spinal ependymoma (excluding subependymoma); OR
 - v. Meningiomas; OR
 - vi. Oligodendroglioma; OR
 - vii. Medulloblastoma; OR
 - viii. Neurofibromatosis type 2 vestibular schwannomas; OR
 - ix. Symptoms due to one of the following (a, b, or c):
 - a) Radiation necrosis; OR
 - b) Brain edema; OR
 - c) Mass effect; AND
- D) The medication is prescribed by or in consultation with an oncologist.

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

2. Cervical Cancer. @

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

- A) Patient is ≥ 18 years of age; AND
- B) Patient meets ONE of the following (i or ii):
 - a. Patient has recurrent or metastatic disease; OR
 - b. Patient has persistent, recurrent, or metastatic small cell neuroendocrine carcinoma of the cervix; AND
- C) The medication is prescribed by or in consultation with an oncologist.

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

3. Colon, Rectal, or Appendiceal Cancer. @

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

- A) Patient is ≥ 18 years of age; AND
- B) Patient has recurrent, advanced or metastatic disease; AND
- C) The medication is used in combination with a chemotherapy regimen; AND

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.
- D) The medication is prescribed by or in consultation with an oncologist.

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

- A) 5 mg/kg administered intravenously not more frequently than once every 2 weeks; OR
- B) 10 mg/kg administered intravenously not more frequently than once every 2 weeks; OR
- C) 7.5 mg/kg administered intravenously not more frequently than once every 3 weeks.

4. Hepatocellular Carcinoma. @

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

- A) Patient is ≥ 18 years of age; AND
- B) Patient meets ONE of the following (i or ii):
 - i. The medication is used as subsequent therapy;^{IC-COMP} OR
 - ii. Patient meets BOTH of the following (a and b):
 - a) Medication is used for first-line therapy; AND
 - b) According to the prescriber, the patient has ONE of the following [(1) or (2)]:
 - (1) Liver-confined, unresectable disease and is deemed ineligible for transplant; OR
 - (2) Extrahepatic/metastatic disease and is deemed ineligible for resection, transplant, or locoregional therapy; AND
- C) The medication is used in combination with Tecentriq (atezolizumab intravenous infusion); AND
- D) The medication is prescribed by or in consultation with an oncologist.

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

5. Non-Small Cell Lung Cancer. @

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

- A) Patient is ≥ 18 years of age; AND
- B) Patient has recurrent, advanced, or metastatic disease; AND
- C) The medication is prescribed by or in consultation with an oncologist.

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

6. Ovarian, Fallopian Tube, or Primary Peritoneal Cancer. @

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

- A) Patient is ≥ 18 years of age; AND
- B) The medication is prescribed by or in consultation with an oncologist.

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

- A) Up to 15 mg/kg administered intravenously not more frequently than once every 3 weeks; OR
- B) 10 mg/kg administered intravenously not more frequently than once every 2 weeks.

7. Renal Cell Cancer. @

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

- A) Patient is ≥ 18 years of age; AND
- B) Patient has relapsed, metastatic, or stage IV disease; AND
- C) The medication is prescribed by or in consultation with an oncologist.

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

Other Uses with Supportive Evidence

8. Ampullary Adenocarcinoma. @

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

- A) Patient is ≥ 18 years of age; AND
- B) Patient has intestinal type disease; AND
- C) The medication is used in combination with chemotherapy; AND
Note: Examples of chemotherapy include FOLFOX (leucovorin, fluorouracil, oxaliplatin), FOLFIRI (leucovorin, fluorouracil, irinotecan), FOLFIRINOX (leucovorin, fluorouracil, oxaliplatin, irinotecan), and CapeOX (capecitabine, oxaliplatin).
- D) The medication is prescribed by or in consultation with an oncologist.

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

9. Endometrial Carcinoma. @

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

- A) Patient is ≥ 18 years of age; AND
- B) Patient has recurrent, advanced, or metastatic disease; AND
- C) The medication is prescribed by or in consultation with an oncologist.

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

10. Mesothelioma. @

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

- A) Patient is ≥ 18 years of age; AND
- B) Patient has one of the following (i, ii, iii, or iv):
 - i. Malignant pleural mesothelioma; OR
 - ii. Malignant peritoneal mesothelioma; OR
 - iii. Pericardial mesothelioma; OR
 - iv. Tunica vaginalis testis mesothelioma; AND
- C) Patient meets ONE of the following (i or ii):
 - i. Bevacizumab will be used in combination with a chemotherapy regimen; OR
Note: Examples of chemotherapy are pemetrexed, cisplatin, carboplatin.
 - ii. Bevacizumab will be used in combination with Tecentriq (atezolizumab intravenous infusion); AND
- D) The medication is prescribed by or in consultation with an oncologist.

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

11. Pediatric Central Nervous System Tumors. @

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

- A) Patient is < 18 years of age; AND
- B) Patient has ONE of the following (i or ii):
 - i. Pediatric-type diffuse high-grade glioma; OR

Note: Examples include diffuse hemispheric glioma, diffuse pediatric-type high-grade glioma, infant-type hemispheric glioma, and diffuse midline glioma.

- ii. Pediatric medulloblastoma; AND
- C) Patient has recurrent or progressive disease; AND
- D) The medication is prescribed by or in consultation with an oncologist.

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

12. Small Bowel Adenocarcinoma. @

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

- A) Patient is ≥ 18 years of age; AND
- B) Patient has advanced or metastatic disease; AND
- C) The medication is used in combination with chemotherapy; AND

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

- D) The medication is prescribed by or in consultation with an oncologist.

Dosing. Approve ONE of the following dosing regimens (A or B):

- A) 5 mg/kg administered intravenously not more frequently than once every 2 weeks; OR
- B) 7.5 mg/kg administered intravenously not more frequently than once every 3 weeks.

13. Soft Tissue Sarcoma. @

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

- A) Patient is ≥ 18 years of age; AND
- B) Patient has ONE of the following (i or ii):
 - i. Angiosarcoma;^{IC-COMP} OR
 - ii. Solitary fibrous tumor;^{IC-COMP} AND
- C) The medication is prescribed by or in consultation with an oncologist.

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

14. Vaginal Cancer. @

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

- A) Patient is ≥ 18 years of age; AND
- B) Patient has advanced, recurrent, or metastatic disease; AND
- C) The medication is prescribed by or in consultation with an oncologist.

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

15. Vulvar Cancer. @

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

- A) Patient is ≥ 18 years of age; AND
- B) Patient has advanced, recurrent, or metastatic disease; AND
- C) The medication is prescribed by or in consultation with an oncologist.

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

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

Other Uses with Supportive Evidence

1. Neovascular or Vascular Ophthalmic Conditions. @

Criteria. Approve for 3 years.

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).

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.

SOURCES OF INFORMATION

- 1. Avastin® intravenous infusion [prescribing information]. South San Francisco, CA: Genentech. September 2022.
- 2. The NCCN Cervical Cancer Clinical Practice Guidelines in Oncology (version 2.2026 – November 10, 2025). © 2025 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed on February 3, 2026.
- 3. The NCCN Colon Cancer Clinical Practice Guidelines in Oncology (version 5.2025 – October 30, 2025). © 2025 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed on February 3, 2026.
- 4. The NCCN Drugs & Biologics Compendium. © 2026 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed on February 3, 2026. Search term: bevacizumab.
- 5. The NCCN Rectal Cancer Clinical Practice Guidelines in Oncology (version 4.2025 – October 31, 2025). © 2025 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed on February 3, 2026.
- 6. The NCCN Central Nervous System Cancers Clinical Practice Guidelines in Oncology (version 3.2025 – December 5, 2025). © 2025 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed on February 3, 2026.
- 7. The NCCN Non-Small Cell Lung Cancer Clinical Practice Guidelines in Oncology (version 3.2026 – December 24, 2025). © 2025 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed on February 3, 2026.
- 8. The NCCN Ovarian Cancer Clinical Practice Guidelines in Oncology (version 3.2025 – July 16, 2025). © 2025 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed on February 3, 2026.
- 9. The NCCN Kidney Cancer Clinical Practice Guidelines in Oncology (version 1.2026 – July 24, 2025). © 2025 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed February 3, 2026.
- 10. The NCCN Mesothelioma: Pleural Clinical Practice Guidelines in Oncology (version 2.2026 – October 3, 2025). © 2025 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed February 3, 2026.
- 11. The NCCN Small Bowel Adenocarcinoma Clinical Practice Guidelines in Oncology (version 1.2026 – January 22, 2026). © 2026 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed February 3, 2026.
- 12. The NCCN Vulvar Cancer Clinical Practice Guidelines in Oncology (version 2.2026 – January 6, 2026). © 2026 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed February 3, 2026.
- 13. The NCCN Uterine Neoplasms Clinical Practice Guidelines in Oncology (version 2.2026 – November 14, 2025). © 2025 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed February 3, 2026.

14. The NCCN Soft Tissue Sarcoma Clinical Practice Guidelines in Oncology (version 1.2026 – January 16, 2026). © 2026 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed February 3, 2026.
15. The NCCN Hepatocellular Carcinoma Clinical Practice Guidelines in Oncology (version 2.2025 – October 22, 2025). © 2025 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed February 3, 2026.
16. The NCCN Mesothelioma: Peritoneal Clinical Practice Guidelines in Oncology (version 2.2026 – October 3, 2025). © 2025 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed February 3, 2026.
17. The NCCN Pediatric Central Nervous System Cancers Clinical Practice Guidelines in Oncology (version 1.2026 – November 25, 2025). © 2025 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed February 3, 2026.
18. The NCCN Ampullary Adenocarcinoma Clinical Practice Guidelines in Oncology (version 1.2026 – January 23, 2026). © 2023 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed February 3, 2026.
19. The NCCN Vaginal Cancer Clinical Practice Guidelines in Oncology (version 2.2026 – December 4, 2025). © 2025 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed February 3, 2026.
20. Escudier B, Pluzanska A, Koralewski P, et al; AVOREN Trial investigators. Bevacizumab plus interferon alfa-2a for treatment of metastatic renal cell carcinoma: a randomised, double-blind phase III trial. *Lancet*. 2007;370:2103-2111.
21. Rini BI, Halabi S, Rosenberg JE, et al. Phase III trial of bevacizumab plus interferon alfa versus interferon alfa monotherapy in patients with metastatic renal cell carcinoma: final results of CALGB 90206. *J Clin Oncol*. 2010;28:2137-2143.
22. Ray-Coguard IL, Domont J, Tresch-Bruneel E, et al. Paclitaxel given once per week with or without bevacizumab in patients with advanced angiosarcoma: A randomized Phase II trial. *J Clin Oncol*. 2015;33:2797-2802.
23. Agulnik M, Yarber JL, Okuno SH, et al. An open-label, multicenter, phase II study of bevacizumab for the treatment of angiosarcoma and epithelioid hemangioendotheliomas. *Ann Oncol*. 2013;24:257-263.
24. Park MS, Patel SR, Ludwig JA, et al. Activity of temozolomide and bevacizumab in the treatment of locally advanced, recurrent, and metastatic hemangiopericytoma and malignant solitary fibrous tumor. *Cancer*. 2011;117:4939-4947.
25. Grill J, Massimino M, Boufett E, et al. Phase II, open-label, randomized, multicenter trial (HERBY) of bevacizumab in pediatric patients with newly diagnosed high-grade glioma. *J Clin Oncol*. 2018;36:951-958.
26. Gulhati P, Raghav K, Schroff RT, et al. Bevacizumab combined with capecitabine and oxaliplatin in patients with advanced adenocarcinoma of the small bowel or Ampulla of Vater: A single-center, open-label, phase 2 study. *Cancer*. 2017;123:1011-1017.
27. Raghav K, Liu S, Overman MJ, et al. Efficacy, safety, and biomarker analysis of combined PD-L1 (atezolizumab) and VEGF (bevacizumab) blockage in advanced malignant peritoneal mesothelioma. *Cancer Discov*. 2021;11:2738-2747.
28. Ceresoli GL, Zucali PA, Mencoboni M, et al. Phase II study of pemetrexed and carboplatin plus bevacizumab as first-line therapy in malignant pleural mesothelioma. *Br J Cancer*. 2013;109:552-558.
29. Aghajanian C, Sill MW, Darcy KM, et al. Phase II trial of bevacizumab in recurrent or persistent endometrial cancer: A Gynecologic Oncology Group Study. *J Clin Oncol*. 2011;29:2259-2265.
30. Rubinstein M, Dickinson S, Narayan P, et al. Bevacizumab in advanced endometrial cancer. *Gynecol Oncol*. 2021;161:720-726.
31. The NCCN Appendiceal Neoplasms and Cancers Clinical Practice Guidelines in Oncology (version 1.2026 – October 30, 2025). © 2025 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed February 3, 2026.
32. Centers for Medicare and Medicaid Services. Memo: Off-label Use of Drugs in Medicare Advantage Step Therapy Programs. Original Date of Memo: 11/05/2021.

HISTORY

Type of Revision	Summary of Changes	Review Date
New policy	--	12/15/2021
Policy revision	Central Nervous System Tumors: Added “Symptoms due to radiation necrosis, poorly controlled vasogenic edema, or mass effect” as additional options for approval. 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. 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. 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. Endometrial Cancer: Removed requirement that the patient has progressed on prior chemotherapy and added requirement that the patient has recurrent, advanced, or metastatic disease. 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.	03/18/2022
Policy revision	Product: Added Alymsys to the list of bevacizumab products.	06/30/2022
Policy revision	Product: Added Vegzelma to the list of bevacizumab products.	01/27/2023
Policy revision	Central Nervous System Tumors: A requirement was added that the patient is ≥ 18 years of age. A Note was added for pediatric patients to refer to the Pediatric Central Nervous System Tumors criteria. Astrocytoma and oligodendroglioma were added as additional options for approval. Cervical Cancer: A requirement was added that the patient is ≥ 18 years of age. The option of approval was added that the patient has persistent, recurrent, or metastatic small cell neuroendocrine carcinoma of the cervix. Colon, Rectal, or Appendiceal Cancer: Appendiceal was added to the condition of approval. A requirement was added that the patient is ≥ 18 years of age. Appendiceal was added to the requirement that the patient has recurrent, advanced, or metastatic disease. Hepatocellular Carcinoma: A requirement was added that the patient is ≥ 18 years of age. A requirement was added that the patient has Child-Pugh Class A disease. Criteria were added that the patient has unresectable or metastatic hepatocellular carcinoma and according to the prescriber, the patient is not a surgical candidate as options for approval. Non-Small Cell Lung Cancer (NSCLC): A requirement was added that the patient is ≥ 18 years of age. A requirement was added that the patient does NOT have a history of recent hemoptysis. Adenocarcinoma, large cell or NSCLC not otherwise specified were moved to a Note. For NSCLC that is negative for actionable mutations, continuation maintenance therapy was added as an option of approval. In combination with other systemic therapies was added to the subsequent therapy option for approval. To the epidermal growth factor receptor exon 19 deletion or exon 21 L858R mutations option for approval, exon 21 descriptor was added. As first-line or continuation maintenance therapy was added to the in combination with erlotinib option of approval. The medication is used as subsequent therapy following prior targeted therapy was added as an option of approval. The medication is used for first-line treatment was added as an option of approval. ERBB2 was added as an option of approval for first-line therapy. Requirements for first-line or subsequent therapy (based on genetic markers) were added. Separately, requirements for subsequent therapy (based on genetic markers) were added. Ovarian, Fallopian Tube, or Primary Peritoneal Cancer: A requirement was added that the patient is ≥ 18 years of age. The descriptor “up to” was added to the recommended dose. Renal Cell Carcinoma: A requirement was added that the patient is ≥ 18 years of age.	04/14/2023

	The descriptor of “advanced” was removed from requirement that the patient has relapsed, metastatic, or stage IV disease. Ampullary Adenocarcinoma: This was added as a new condition of approval. Endometrial Carcinoma: A requirement was added that the patient is ≥ 18 years of age. The frequency of dosing was changed from once every 2 weeks to once every 3 weeks. Mesothelioma: A requirement was added that the patient is ≥ 18 years of age. Bevacizumab was removed if used as a single agent for maintenance therapy as an option of approval. Pediatric central Nervous System Tumors: This was added new condition of approval. Small Bowel Adenocarcinoma: A requirement was added that the patient is ≥ 18 years of age. A requirement was added that the patient has advanced or metastatic disease. Soft Tissue Sarcoma: A requirement was added that the patient is ≥ 18 years of age. Vulvar Cancer: Squamous cell carcinoma was removed from the condition of approval. A requirement was added that the patient is ≥ 18 years of age. A requirement was added that the patient has advanced, recurrent, or metastatic disease. The descriptor “up to” was removed from the recommended dosing regimen. The frequency of dosing was changed from once every 2 weeks to once every 3 weeks.	
Policy revision	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. 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. Mesothelioma: Removed “malignant” from malignant pleural mesothelioma and malignant peritoneal mesothelioma. Pediatric Central Nervous System Tumors: Added pediatric medulloblastoma as an option for approval. Removed requirement that the medication is used for palliation.	04/16/2024
Policy revision	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. 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. 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. Vaginal Cancer: Added new condition of approval. Vulvar Cancer: Removed bevacizumab is used in combination with a chemotherapy regimen as a requirement. Formatting and notation updates. Revision based on commercial policy criteria changes.	03/17/2025
Policy revision	Jobevne (bevacizumab-nwgd) was added to the policy; the same criteria apply as the other bevacizumab products.	09/22/2025

Policy revision	Hepatocellular Carcinoma: The duration of approval was changed to 1 year. The option of approval along with the associated notes to approve for 1 year (total) was removed. The option of approval that the medication is used as subsequent therapy was added. Non-Small Cell Lung Cancer: The requirement that the patient does not have a history of recent hemoptysis was removed. The requirement that the patient has recurrent, advanced, or metastatic non-squamous non-small cell lung cancer (NSCLC) was modified to the patient has recurrent, advanced, or metastatic disease. The requirement that the patient meets one of the following was removed: the tumor is negative or unknown for actionable mutations; the tumor is positive for (EGFR) exon 19 deletion or exon 21 L858R mutations; the medication is used as first-line; the medication is used as first-line or subsequent therapy; and the medication is used as subsequent therapy. Small Bowel Adenocarcinoma: Added 5 mg/kg administered intravenously not more frequently than every 2 weeks to the approval dosing regimens. The dosing was modified to 7.5 mg/kg administered intravenously not more frequently than once every 3 weeks. Previously, approved up to 7.5 mg/kg administered intravenously not more frequently than once every 2 weeks. Soft Tissue Sarcoma: The requirement that the patient has angiosarcoma or solitary fibrous tumor was modified to the patient has ONE of the following: Angiosarcoma or Solitary fibrous tumor.	03/24/2026
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