Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines:
Medical Benefit Drugs

Avastin® (bevacizumab) For Ophthalmic Conditions

Effective: April 14, 2026

Guideline Type	☒ Prior Authorization ☐ Non-Formulary ☐ Step-Therapy ☐ Administrative

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; Fax 617-673-0988

☐ Tufts Health Plan Commercial products; Fax 617-673-0988

Public Plans Products

☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax 617-673-0988

☐ Tufts Health Together – MassHealth Accountable Care Partnership Plans; Fax 617-673-0939

☐ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax 617-673-0939

☐ Tufts Health One Care* – a Medicare-Medicaid plan (a dual-eligible product); Fax 617-673-0956

*The MNG applies to Tufts Health One Care members unless a less restrictive LCD or NCD exists.

Senior Products

☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); Fax 617-673-0956

☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); Fax 617-673-0956

☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); Fax 617-673-0956

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

Overview

Food and Drug Administration (FDA)-Approved Indications

Evidence is indicated in the treatment of metastatic colorectal cancer; first-line non-squamous non-small cell lung cancer; recurrent glioblastoma; metastatic renal cell carcinoma; persistent, recurrent, or metastatic cervical cancer; epithelial ovarian, fallopian tube, or primary peritoneal cancer; and hepatocellular carcinoma.

Note: *Providers and Members enrolled with Harvard Pilgrim Health Care may reference the HPHC/OncoHealth guideline for coverage of oncology-related indications, located at https://oncohealth.us/medicalpolicies/harvardpilgrim/*

Evidence demonstrates that Lucentis and Avastin appear to have similar effects on visual acuity in patients with Wet age-related macular degeneration. When compared head-to-head, the visual acuity outcomes after treatment with Avastin and Lucentis were similar (*Cochrane Database Syst Rev*, 2014)

In addition, evidence demonstrates Eylea, Avastin, and Lucentis improve vision in eyes with center-involved diabetic macular edema, but the relative effect depended on baseline visual acuity. When the initial visual-acuity loss was mild, there were no apparent differences, on average, among treatment groups.

Clinical Guideline Coverage Criteria

The plan may cover Avastin (bevacizumab) for Members when **ALL** of the following criteria are met:

1. Documented diagnosis of an ophthalmic condition

Limitations

None

Codes

The following code(s) require prior authorization:

Table 1: HCPCS Codes

HCPCS Codes	Description
J9035	Injection, bevacizumab, 10 mg

References:

1. Avastin (bevacizumab). South San Francisco, CA; Genentech, Inc.: 2022 September.
2. The Diabetic Retinopathy Clinical Research Network. Aflibercept, bevacizumab, or ranibizumab or diabetic macular edema. N Engl J Med. 2015;372:1193-1203.
3. Solomon S, et al. Anti-vascular endothelial growth factor for neovascular age-related macular degeneration. Cochrane Database Syst Rev. 2014 Aug 29;8(8):CD005139.
4. National Institutes of Health, National Eye Institute. Age-Related Macular Degeneration (AMD) Data and Statistics. Updated July 17, 2019.
5. Flaxel CJ, et al. Age-related macular degeneration Preferred Practice Pattern. Ophthalmology. 2020 Jan;127(1):P1-P65.

Approval And Revision History

September 13, 2022: Reviewed by Pharmacy and Therapeutics Committee (P&T).

September 21, 2022: Reviewed by the Medical Policy Approval Committee (MPAC).

Subsequent endorsement date(s) and changes made:

- May 14, 2024: Removed Reauthorization Criteria (eff 6/1/24).
- April 8, 2025: Updated diagnosis requirements to “Documented diagnosis of an ophthalmic condition.” Administrative update to remove Harvard Pilgrim Health Care Stride Medicare Advantage from the Medical Necessity Guideline template. (eff 5/1/25)
- June 2025: Administrative Update: Updated from Tufts Unify to Tufts One Care to reflect name change
- April 14, 2026: Administrative updates: Template updated to remove CareLink from the Medical Necessity Guideline template. Template updated from “Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans” to “Tufts Health Together- MassHealth Accountable Care Partnership Plans.” (eff 4/14/26)

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member’s benefit document, and in coordination with the Member’s physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.