

(rituximab) RITUXAN PRIOR APPROVAL REQUEST

Send completed form to: FAX: 855-895-3504 FOR URGENT FAX: 844-244-0226

Federal Employee Program. PR

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					required)
Date:			Provider Name:		
		Specialty:		NPI:	
Sex: Dale	Gemale	Office Phone:		Office Fax:	
Street Address:			Office Street Address:		
State:	Zip:	City:	Stat	e:	Zip:
		Physician Signature:			
P	HYSICIAN	COMPLETES			
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- 4. Does the patient have any active bacterial, invasive fungal, viral, and other opportunistic infections? \Box Yes \Box No
- Will Rituxan be used in combination with another biologic *disease-modifying antirheumatic drug (DMARD) or targeted synthetic DMARD? □Yes* □No
 - *If YES, please specify the medication: _

*DMARDs: Actemra, Avsola, Cimzia, Cosentyx, Enbrel, Entyvio, Humira, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR

6. What is the patient's diagnosis?

Chronic Lymphocytic Leukemia (CLL)	Primary central nervous system lymphoma	
Hodgkin's lymphoma	Refractory autoimmune hemolytic anemia	
Immune thrombocytopenic purpura	□ Steroid refractory chronic graft vs. host disease	
Leptomeningeal metastases	Thrombotic thrombocytopenic purpura	
□ Mature B-cell acute leukemia	Waldenström's macroglobulinemia	
Cronulomatoria W/nolyangiitis (formerly Wegener's	(granulomatosis)	

Granulomatosis w/polyangiitis (formerly Wegener's granulomatosis)

a. Is the patient currently taking a glucocorticoid? \Box Yes \Box No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

PAGE 1 of 2

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification**: I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Rituxan – FEP MD Fax Form Revised 4/21/2023



 BlueShield.
 (rituximab) RITUXAN

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 PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

PAGE 2 - PHYSICIAN COMPLETES					
Patient Name: DO	DB:	Patient ID: R			
Gamma Microscopic Polyangiitis (MPA)					
a. Is the patient currently taking a glucocortic	coid? 🛛 Yes 🖓 No				
□ Myastenia Gravis (MG)					
a. Does the patient have refractory myastheni	a gravis? 🛛 Yes 🖓 No				
b. Has the patient been on Rituxan continuou	sly for the last 6 months , <u>exc</u>	cluding samples? QYes No*			
* <i>If NO</i> , does the patient have an intolera least TWO conventional therapies for M methotrexate, tacrolimus, cyclophosphar	G (e.g., corticosteroids, azat	we they had an inadequate treatment response to at hioprine, mycophenolate, cyclosporine,			
Non-Hodgkin Lymphoma (NHL)					
a. Does the patient have B-cell non-Hodgkin	lymphoma? □Yes □No*				
*If NO, please specify:					
b. Which type of lymphoma/leukemia does th	ne patient have? Please selec	t one of the following below:			
 AIDS-related B-cell lymphomas Burkitt lymphoma Burkitt-like lymphoma Castleman's disease Diffuse Large B-Cell Lymphoma (DLBCL) Other type (<i>please specify</i>):		 Non-gastric MALT lymphoma Post-transplant lymphoproliferative disorder Primary cutaneous B-cell lymphoma Splenic marginal zone lymphoma 			
c. Is the lymphoma/leukemia CD20-positive?	P Tyes No				
Pemphigus Vulgaris (PV)					
a. Has the patient been on Rituxan continuo	usly for the last 6 months , <u>ex</u>	ccluding samples? Yes No*			
*If NO, does the patient have moderate	to severely active pemphigu	s vulgaris? 🛛 Yes 🖓 No			
 Rheumatoid Arthritis (RA) a. Has the patient been on Rituxan continuous *If NO, please answer the following que i. Does the patient have moderate to set the patient have moderate	stions:				
ii. Does the patient have an intolerand more tumor necrosis factor (TNF) a		e they had an inadequate treatment response to one or □No			
Systemic Lupus Erythematosus (SLE)					
a. Does the patient have refractory systemic l	upus erythematosus?	□No			
Other diagnosis (<i>please specify</i>):					

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