

## (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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	State: State: State: State: State: Price State:	State:       Zip:         PHYSICIAN         Rituxan         PHYSICIAN         Rituxan         eck www.fepblue.org/formulary to confir         NOTE: Form must be comple         eck www.fepblue.org/formulary to confir         NOTE: Form must be comple         eck www.fepblue.org/formulary to confir         NOTE: Form must be comple         eric?       Brand         Generic         tient, for claims adjudicated three         oni       Ruxience         ave an intolerance or contraindica         oducts: Riabni, Ruxience, or Trux         result(s)):         eason for not trying TWO of the p         specify:         her live or non-live vaccines while	Sex:       Male       Female       Office Phone:         Office Street Address:       Office Street Address:         State:       Zip:       City:         Physician Signature:       Physician Signature:         PHYSICIAN COMPLETES         Rituxan (rituximab)         ext www.fepblue.org/formulary to confirm which medication is part of NOTE: Form must be completed in its entirety for proceed of the pharmacy beneric?         Brand       Generic         tient, for claims adjudicated through the pharmacy beneric         oni       Ruxience         Truxima       No*         wave an intolerance or contraindication or have they had an i oducts: Riabni, Ruxience, or Truxima? Please select answe result(s)):         eason for not trying TWO of the preferred products?       Yes         eason for not trying TWO of the preferred products?       Yes         ent live or non-live vaccines while on Rituxan? Please select       Please select	Sex:       Male       Female       Office Phone:         Office Street Address:       Office Street Address:       State:       Zip:       City:       State         Physician Signature:       Physician Signature:       Physician Signature:       Physician Signature:         PHYSICIAN COMPLETES       Physician Signature:       Physician Signature:       Physician Signature:         NOTE: Form must be completed in its entirety for processing       Physician Signature:       Physician Signature:         Poni       Processing       Ono*       Physician Signature:       Physician Signature:         Physician Signature:       Physician Signature:       Physician Signature: <t< td=""><td>Sex:       Male       Female       Office Phone:       Office Fax:         Office Street Address:        Office Street Address:          State:       Zip:       City:       State:          Physician Signature:       Physician Signature:           PHYSICIAN COMPLETES       PHYSICIAN COMPLETES           Rituxan (rituximab)       State:            sck www.fepblue.org/formulary to confirm which medication is part of the patient's benefit       NOTE: Form must be completed in its entirety for processing          scric?       Brand       Generic            tient, for claims adjudicated through the pharmacy benefit:       Would you like to so on i antolerance or contraindication or have they had an inadequate treatment resoducts:          ave an intolerance or contraindication or have they had an inadequate treatment resoducts:            eason for not trying TWO of the preferred products?       Yes*       No          eason for not trying TWO of the preferred products?       Yes*       No         ener live or non-live vaccines while on Rituxan? Please select answer below:</td></t<>	Sex:       Male       Female       Office Phone:       Office Fax:         Office Street Address:        Office Street Address:          State:       Zip:       City:       State:          Physician Signature:       Physician Signature:           PHYSICIAN COMPLETES       PHYSICIAN COMPLETES           Rituxan (rituximab)       State:            sck www.fepblue.org/formulary to confirm which medication is part of the patient's benefit       NOTE: Form must be completed in its entirety for processing          scric?       Brand       Generic            tient, for claims adjudicated through the pharmacy benefit:       Would you like to so on i antolerance or contraindication or have they had an inadequate treatment resoducts:          ave an intolerance or contraindication or have they had an inadequate treatment resoducts:            eason for not trying TWO of the preferred products?       Yes*       No          eason for not trying TWO of the preferred products?       Yes*       No         ener live or non-live vaccines while on Rituxan? Please select answer below:

- 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

 Federal Employee Program.
 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 <b>6 months</b> , <u>exc</u>	cluding samples?  QYes  No*			
* <i>If NO</i> , does the patient have an intolera least <b>TWO</b> 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:			
<ul> <li>AIDS-related B-cell lymphomas</li> <li>Burkitt lymphoma</li> <li>Burkitt-like lymphoma</li> <li>Castleman's disease</li> <li>Diffuse Large B-Cell Lymphoma (DLBCL)</li> <li>Other type (<i>please specify</i>):</li></ul>		<ul> <li>Non-gastric MALT lymphoma</li> <li>Post-transplant lymphoproliferative disorder</li> <li>Primary cutaneous B-cell lymphoma</li> <li>Splenic marginal zone lymphoma</li> </ul>			
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 <b>6 months</b> , <u>ex</u>	ccluding samples?  Yes  No*			
*If NO, does the patient have moderate	to severely active pemphigu	s vulgaris? 🛛 Yes 🖓 No			
<ul> <li>Rheumatoid Arthritis (RA)</li> <li>a. Has the patient been on Rituxan continuous</li> <li>*If NO, please answer the following que</li> <li>i. Does the patient have moderate to set the patient have moderate</li></ul>	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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