BlueCross BlueShield Federal Employee Program

(rituximab) RITUXAN PRIOR APPROVAL REQUEST

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

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.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Rituxan (rituximab)

****Check 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

Is this request for brand or generic? ❑Brand ❑Generic

1. **Standard/Basic Option Patient, for claims adjudicated through the pharmacy benefit:** Would you like to switch the patient to a preferred product? ❑Riabni ❑Ruxience ❑Truxima ❑No*

   If NO,** does the patient have an intolerance or contraindication or have they had an inadequate treatment response to **TWO** of the following preferred products: Riabni, Ruxience, or Truxima? ***Please select answer below:

   ❑ **Yes** ***(specify drug(s) and result(s))***: _____

   _____

   ❑**No**: Is there a clinical reason for not trying **TWO** of the preferred products? ❑Yes* ❑No

   If YES, please specify: _____

   _____

2. Will the patient be given either live or non-live vaccines while on Rituxan? ***Please select answer below:***
   ❑Live vaccines ❑Non-live vaccines ❑Live and non-live vaccines ❑No vaccines will be administered
3. **If Non-Live Vaccines**: Will non-live vaccines be administered at least four weeks prior to a course of Rituxan? ❑Yes ❑No
4. Does the patient have any active bacterial, invasive fungal, viral, and other opportunistic infections? ❑Yes ❑No
5. 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)
   ❑Hodgkin's lymphoma
   ❑Immune thrombocytopenic purpura
   ❑Leptomeningeal metastases
   ❑Mature B-cell acute leukemia
   ❑Primary central nervous system lymphoma
   ❑Refractory autoimmune hemolytic anemia
   ❑Steroid refractory chronic graft vs. host disease
   ❑Thrombotic thrombocytopenic purpura
   ❑Waldenström's macroglobulinemia

   ❑Granulomatosis w/polyangiitis (formerly Wegener's granulomatosis)

   a. Is the patient currently taking a glucocorticoid? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ **DOB:** _____ **Patient ID: R** _____

❑ Microscopic Polyangiitis (MPA)

a. Is the patient currently taking a glucocorticoid? ❑Yes ❑No

❑ Myastenia Gravis (MG)

a. Does the patient have refractory myasthenia gravis? ❑Yes ❑No

b. Has the patient been on Rituxan continuously for the last **6 months**, excluding samples? ❑Yes ❑No*

***If NO,** does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least **TWO** conventional therapies for MG (e.g., corticosteroids, azathioprine, mycophenolate, cyclosporine, methotrexate, tacrolimus, cyclophosphamide, etc.)? ❑Yes ❑No

❑ 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 the patient have? ***Please select one of the following below:***

❑AIDS-related B-cell lymphomas
❑Burkitt lymphoma
❑Burkitt-like lymphoma
❑Castleman's disease
❑Diffuse Large B-Cell Lymphoma (DLBCL)
❑Follicular lymphoma
❑Gastric MALT lymphoma
❑Hairy cell leukemia
❑Mantle cell lymphoma
❑Nodal marginal zone lymphoma
❑Non-gastric MALT lymphoma
❑Post-transplant lymphoproliferative disorder
❑Primary cutaneous B-cell lymphoma
❑Splenic marginal zone lymphoma
❑Other type ***(please specify)***: _____

c. Is the lymphoma/leukemia CD20-positive? ❑Yes ❑No

❑ Pemphigus Vulgaris (PV)

a. Has the patient been on Rituxan continuously for the last **6 months**, excluding samples? ❑Yes ❑No*

***If NO**, does the patient have moderate to severely active pemphigus vulgaris? ❑Yes ❑No

❑ Rheumatoid Arthritis (RA)

a. Has the patient been on Rituxan continuously for the last **6 months**, excluding samples? ❑Yes ❑No*

***If NO,** please answer the following questions:

i. Does the patient have moderate to severely active rheumatoid arthritis? ❑Yes ❑No

ii. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to one or more tumor necrosis factor (TNF) antagonist therapies? ❑Yes ❑No

❑ Systemic Lupus Erythematosus (SLE)

a. Does the patient have refractory systemic lupus erythematosus? ❑Yes ❑No

❑ Other diagnosis **(*please specify*):** _____