BlueCross BlueShield Federal Employee Program

# (rituximab-arrx) Riabini, (rituximab-pvvr) Ruxience, (rituximab-abbs) Truxima
# RITUXIMAB
# 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** | | | | | |

**NOTE**: Form must be completed in its **entirety** for processing

**Please select medication:**

❑**Riabni (rituximab-arrx)** ❑**Ruxience (rituximab-pvvr)** ❑**Truxima (rituximab-abbs)**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

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

1. Will the patient be given either live or non-live vaccines while on therapy? ***Please select answer below:***
   ❑Live vaccines ❑Non-live vaccines ❑Live and non-live vaccines ❑No vaccines will be administered
2. **If Non-Live Vaccines**: Will non-live vaccines be administered at least four weeks prior to a course of the requested therapy? ❑Yes ❑No
3. Does the patient have any active bacterial, invasive fungal, viral, and other opportunistic infections? ❑Yes ❑No
4. Will this medication 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, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR***
5. **Standard/Basic Option Patient, <u>for claims adjudicated through the pharmacy benefit</u>**: Has the patient been on this medication continuously for the last **6 months**, <u>excluding samples</u>? ❑Yes ❑No*
   ****If NO***, is this medication being requested as a change from Rituxan or Rituxan Hycela to allow the member access to their copay benefit? ❑Yes* ❑No
   ****If YES***, please select the medication: ❑Rituxan **<u>OR</u>** ❑Rituxan Hycela
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
   - ❑ Microscopic Polyangiitis (MPA)
     a. Is the patient currently taking a glucocorticoid? ❑Yes ❑No

**PLEASE PROCEED TO <u>PAGE 2</u> FOR ADDITIONAL DIAGNOSES**

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## PAGE 2 - PHYSICIAN COMPLETES

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

❑ Myastenia Gravis (MG)

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

b. Has the patient been on this medication 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 leukemia/lymphoma 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 leukemia/lymphoma CD20-positive? ❑Yes ❑No

❑ Pemphigus Vulgaris (PV)

a. Has the patient been on this medication 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 this medication 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*):** _____