



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.

Form with sections: Patient Information (required), Provider Information (required), and PHYSICIAN COMPLETES. Includes fields for Date, Patient Name, Date of Birth, Sex, Street Address, City, State, Zip, Patient ID, Provider Name, Specialty, NPI, Office Phone, Office Fax, Office Street Address, City, State, Zip, and Physician Signature.

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, for claims adjudicated through the pharmacy benefit: Has the patient been on this medication continuously for the last 6 months, excluding samples? 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 OR Rituxan Hycela
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
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 PAGE 2 FOR ADDITIONAL DIAGNOSES

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. Rituximab - FEP MD Fax Form Revised 4/21/2023



BlueCross
BlueShield

Federal Employee Program.

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PAGE 2 - PHYSICIAN COMPLETES

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

Myasthenia 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:*

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

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*): _____