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

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.

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*):** _____