Rituxan Hycela

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756** to initiate the review process. If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Drug Information:

Strength/Measure _____*Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un

Directions(sig) _____*Route of administration* _____

Dosing frequency _____

What is the ICD-10 code? _____

Exception Criteria Questions:

A. The preferred products for your patient's health plan are Riabni, Ruxience, and Truxima. Can the patient's treatment be switched to a preferred product?
   ❑ Yes – Riabni, *Please obtain Form for preferred product and submit for corresponding PA.*
   ❑ Yes – Ruxience, *Please obtain Form for preferred product and submit for corresponding PA.*
   ❑ Yes – Truxima, *Please obtain Form for preferred product and submit for corresponding PA.*
   ❑ No

B. Does the patient have a documented intolerable adverse event to all of the preferred products (Riabni, Ruxience, and Truxima)? ***ACTION REQUIRED: If 'Yes', attach supporting chart note(s).*** ❑ Yes ❑ No

C. Was the documented intolerable adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the reference product and biosimilar products)? ***ACTION REQUIRED: If 'No', attach supporting chart note(s).*** ❑ Yes ❑ No

Send completed form to: Priority Partners Fax: 1-866-212-4756

Site of Service Questions:

A. Indicate the site of service requested:
- ❑ *Ambulatory Surgical (POS Code 24)*
- ❑ *Off Campus Outpatient Hospital (POS Code 19)*
- ❑ *Office (POS Code 11)*
- ❑ *Home (POS Code 12)*
- ❑ *On Campus Outpatient Hospital (POS Code 22)*

B. Is the patient less than 18 years of age?
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No

C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, other pre- medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

D. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

F. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

G. Has the patient's home been deemed not eligible or appropriate for home infusion services by a home infusion provider? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

H. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?
ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation. ❑ Yes ❑ No

Criteria Questions:

1. Is this a request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 2*
❒ No, *Continue to 4*

2. What is the diagnosis?
❒ Diffuse large B-cell lymphoma (DLBCL), CD20 positive, *Continue to 3*
❒ Chronic lymphocytic leukemia (CLL) / Small lymphocytic lymphoma (SLL), CD20 positive, *Continue to 3*
❒ Follicular lymphoma (FL), CD20 positive, *Continue to 3*
❒ Histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma, *Continue to 3*

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❒ Castleman's disease (CD), CD20 positive, *Continue to 3*
❒ Extranodal marginal zone lymphoma (gastric and non-gastric MALT lymphoma), CD20 positive, *Continue to 3*
❒ High-grade B-cell lymphoma (including high-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 [double/triple hit lymphoma], high-grade B-cell lymphoma, not otherwise specified), CD20 positive, *Continue to 3*
❒ Mantle cell lymphoma, CD20 positive, *Continue to 3*
❒ Nodal marginal zone lymphoma, CD20 positive, *Continue to 3*
❒ Primary cutaneous B-cell lymphoma (e.g., cutaneous marginal zone lymphoma or cutaneous follicle center lymphomas), CD20 positive, *Continue to 3*
❒ Post-transplant lymphoproliferative disorder (PTLD), CD20 positive, *Continue to 3*
❒ Splenic marginal zone lymphoma, CD20 positive, *Continue to 3*
❒ Hairy cell leukemia, CD20 positive, *Continue to 3*
❒ Waldenstrom Macroglobulinemia / Lymphoplasmacytic Lymphoma, CD20 positive, *Continue to 3*
❒ Hodgkin lymphoma, nodular lymphocyte-predominant, CD20 positive, *Continue to 3*
❒ Other, please specify. _____, *Continue to 3*

3. Is there evidence of unacceptable toxicity while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

4. What is the diagnosis?
❒ Diffuse large B-cell lymphoma (DLBCL), *Continue to 5*
❒ Chronic lymphocytic leukemia (CLL) / Small lymphocytic lymphoma (SLL), *Continue to 5*
❒ Follicular lymphoma (FL), *Continue to 5*
❒ Histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma, *Continue to 5*
❒ Castleman's disease (CD), *Continue to 5*
❒ Extranodal marginal zone lymphoma (gastric and non-gastric MALT lymphoma), *Continue to 5*
❒ High-grade B-cell lymphoma (including high-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 [double/triple hit lymphoma], high-grade B-cell lymphoma, not otherwise specified), *Continue to 5*
❒ Mantle cell lymphoma, *Continue to 5*
❒ Nodal marginal zone lymphoma, *Continue to 5*
❒ Primary cutaneous B-cell lymphoma (e.g., cutaneous marginal zone lymphoma or cutaneous follicle center lymphomas), *Continue to 5*
❒ Post-transplant lymphoproliferative disorder (PTLD), *Continue to 5*
❒ Splenic marginal zone lymphoma, *Continue to 5*
❒ Hairy cell leukemia, *Continue to 5*
❒ Waldenstrom Macroglobulinemia / Lymphoplasmacytic Lymphoma, *Continue to 5*
❒ Hodgkin lymphoma, nodular lymphocyte-predominant, *Continue to 5*
❒ Other, please specify. _____, *Continue to 5*

5. Does the patient have CD20 positive disease that was confirmed by testing or analysis? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results confirming CD20 protein on the surface of the B-cell.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 6*

❒ No, *Continue to 6*

❒ Unknown, *Continue to 6*

6. Has the patient received at least one full dose of a rituximab product by IV infusion without experiencing severe adverse reactions?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Priority Partners Fax: 1-866-212-4756

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076

Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.hopkinshealthplans.org