BlueCross BlueShield
Federal Employee Program

RITUXAN
PRIOR APPROVAL REQUEST

Member Information (required)	Provider Information (required
Date:	**Provider Name:**
Cardholder Name:	**Specialty:** **NPI:**
Member Name:	**Office Phone:**
Date of Birth: **Sex:** **Male** ☐ **Female** ☐	**Office Fax;**
Street Address:	**Office Street Address:**
City: **State:** **Zip:**	**City:** **State:** **Zip:**
Cardholder ID R	**Physician Signature:**

HCPCS (J code):
CPT Codes:
ICD-10 Codes:
Dose/Route/Frequency:
Patient Height/Weight:
Is this request for ☐ initiation or ☐ continuation?

PHYSICIAN COMPLETES

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

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

1. What is the patient's diagnosis?

❑Chronic Lymphocytic Leukemia (CLL)

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

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

❑Hodgkin's lymphoma

❑Immune thrombocytopenic purpura

❑Leptomeningeal metastases

❑Microscopic polyangiitis (MPA)

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

❑ Non-Hodgkin Lymphoma (NHL)

a. Does the patient have B-cell non-Hodgkin lymphoma? ❑Yes ❑No

b. Is the lymphoma/leukemia CD20-Positive? ❑Yes ❑No

c. What type of lymphoma/leukemia does the patient have? ***Please select one of the following below:***

❑ AIDS-Related B-cell lymphomas	❑ Burkitt lymphoma	❑ Castleman's disease
❑ Diffuse large B-cell 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
❑ Other type ***(please specify)***: __		

☐Pemphigus vulgaris (PV)

a. Has the patient been on Rituxan therapy continuously for the last **6 months**? ☐Yes ☐No*

***If NO**, is the patient's pemphigus vulgaris moderately to severely active? ☐Yes ☐No

☐Primary central nervous system lymphoma

☐Refractory autoimmune hemolytic anemia

Fax Number: 1-855-895-3504	Phone Number: 1-800-633-4581

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☐ Rheumatoid arthritis (RA)

a. Has the patient been on Rituxan therapy continuously for the last **6 months**? ☐ Yes ☐ No*

If NO, please answer the following questions:

i. Is the patient's rheumatoid arthritis moderately to severely active? ☐ Yes ☐ No

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

☐ Steroid refractory chronic graft vs. host disease

☐ Thrombotic thrombocytopenic purpura

☐ Waldenström's macroglobulinemia

☐ Other diagnosis (please specify):

2. Do you agree the patient will not receive a live vaccine while on Rituxan and non-live vaccines should be administered four weeks prior to a course of Rituxan? ☐ Yes ☐ No

3. Does the patient have any active, bacterial, invasive fungal, viral and other opportunistic infections? ☐ Yes ☐ No

4. Will Rituxan be used with another biologic or targeted synthetic DMARD**? ☐ Yes* ☐ No

If YES, please specify:

**DMARD includes: Actemra, Cimzia, Cosentyx, Enbrel, Entyvio, Humira, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Siliq, Simponi, Stelara, Taltz, Tremfya, and Xeljanz

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.

Physician Name (print clearly):	Phone:	Fax:	
Street Address:	City:	State:	Zip:
Prescribers NPI:	Physician Signature:		Date:

View our Medical Policy on line at https://www.fepblue.org/en/benefit-plans/benefit-plans-brochures-and-forms#