BlueCross BlueShield Federal Employee Program

(rituximab and hyaluronidase human)
RITUXAN HYCELA
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					

Rituxan Hycela

(rituximab and hyaluronidase human)

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

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

1. Has the patient been on Rituxan Hycela continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 3**
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. **Standard/Basic Option Patient:** Would you like to switch the patient to a preferred product? ***Please select answer below:***
   ❑**Yes,** please select a preferred product: ❑Riabni ❑Ruxience ❑Truxima
   ❑**No**: Does the patient have an intolerance or contraindication to or have they had an inadequate treatment response to a preferred product, Riabni, Ruxience, and/or Truxima? ***Please select answer below:***
   ❑**Yes** ***(please select one of the following)***: ❑Patient has tried one drug ❑Patient has tried two or more drugs
   ***Please specify drug(s) and result(s): _____
   _____
   ❑**No**: Is there a clinical reason for not trying Riabni, Ruxience, and/or Truxima? ❑Yes* ❑No
   If YES, please specify: _____
4. What is the patient's diagnosis?
   ❑Chronic Lymphocytic Leukemia (CLL)
   a. Will Rituxan Hycela be used in combination with fludarabine and cyclophosphamide (FC)? ❑Yes ❑No
   ❑Diffuse large B-cell lymphoma
   a. Will Rituxan Hycela be used in combination with cyclophosphamide, doxorubicin, vincristine, prednisone (CHOP) or other anthracycline-based chemotherapy regimens? ❑Yes ❑No
   ❑Follicular lymphoma
   a. Is the patient's follicular lymphoma relapsed or refractory? ❑Yes ❑No
   b. Will Rituxan Hycela be used in combination with first line chemotherapy? ❑Yes ❑No
   c. Is the patient's follicular lymphoma non-progressing after first-line cyclophosphamide, vincristine, and prednisone (CVP) chemotherapy? ❑Yes ❑No
   ❑Other diagnosis **(*please specify*):** _____
5. Has the patient received at least one full dose of a rituximab product by intravenous infusion? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL INITIATION QUESTIONS

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R_____

6. Will the patient be given either live or non-live vaccines while on therapy? ❑Yes***** ❑No vaccines will be administered
   ****If YES***, select one of the following: ❑Live vaccines ❑Non-live vaccines***** ❑Both, live and non-live vaccines
   ****If Non-Live Vaccines***, will non-live vaccines be administered at least 4 weeks prior to a course of therapy? ❑Yes ❑No

7. Does the patient have a history of Hepatitis B (HBV) infection? ❑Yes***** ❑No
   ****If YES***, does the prescriber agree to monitor for Hepatitis B reactivation? ❑Yes ❑No

8. Does the patient have any severe active infections? ❑Yes ❑No

9. Does the prescriber agree to monitor for signs of progressive multifocal leukoencephalopathy (PML) or severe mucocutaneous reactions? ❑Yes ❑No

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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					

For Standard and Basic Option patients Riabni, Ruxience, and Truxima are preferred products. Please consider prescribing a preferred product. Standard and Basic Option patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year.

CONTINUATION OF THERAPY (PA RENEWAL)
Rituxan Hycela
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****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

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1. Has the patient been on Rituxan Hycela continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   - ❑**NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 1**
   - ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. **Standard/Basic Option Patient:** Would you like to switch the patient to a preferred product? ***Please select answer below:***
   - ❑**Yes,** please select a preferred product: ❑Riabni ❑Ruxience ❑Truxima
   - ❑**No**: Does the patient have an intolerance or contraindication to or have they had an inadequate treatment response to a preferred product, Riabni, Ruxience, and/or Truxima? ***Please select answer below:***
     - ❑**Yes *(please select one of the following)***: ❑Patient has tried one drug ❑Patient has tried two or more drugs
       *****Please specify drug(s) and result(s): _____
       _____
     - ❑**No**: Is there a clinical reason for not trying Riabni, Ruxience, and/or Truxima? ❑Yes***** ❑No
       ****If YES***, please specify: _____
4. What is the patient's diagnosis?
   - ❑Chronic Lymphocytic Leukemia (CLL)
   - ❑Diffuse large B-cell lymphoma
   - ❑Follicular lymphoma
   - ❑Other diagnosis ***(please specify)*:** _____
5. Has the patient had a disease progression or unacceptable toxicity? ❑Yes ❑No
6. Will the patient be given either live or non-live vaccines while on therapy? ❑Yes***** ❑No vaccines will be administered
   ****If YES***, select one of the following: ❑Live vaccines ❑Non-live vaccines***** ❑Both, live and non-live vaccines
   ****If Non-Live Vaccines***, will non-live vaccines be administered at least 4 weeks prior to a course of therapy? ❑Yes ❑No
7. Does the patient have a history of Hepatitis B (HBV) infection? ❑Yes***** ❑No
   ****If YES***, does the prescriber agree to monitor for Hepatitis B reactivation? ❑Yes ❑No
8. Does the patient have any severe active infections? ❑Yes ❑No
9. Does the prescriber agree to monitor for signs of progressive multifocal leukoencephalopathy (PML) or severe mucocutaneous reactions? ❑Yes ❑No