OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

PHARMACY/MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-844-348-3720**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **Incomplete form will delay authorization process**.

Drug Requested: Rituxan Hycela™ (rituximab and hyaluronidase) **(J9999) (Medical) (Non-Preferred)**

Medication being provided by a Physician's office only.

DRUG INFORMATION: Complete information below or authorization will be delayed.

Drug Form/Strength/Month: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

CLINICAL CRITERIA: Complete below **ALL** lines for appropriate diagnosis. Authorization might be delayed if boxes for diagnosis are **NOT** checked.

All patients **MUST** receive at least one full dose of intravenous rituximab (without experiencing severe adverse reactions) prior to initiating treatment with subcutaneous rituximab/hyaluronidase; patients who do not tolerate a full IV dose should continue to receive IV rituximab in subsequent cycles. Patient may be switched to subcutaneous rituximab/hyaluronidase injection after a full IV dose has been successfully administered.

- **Has patient successfully received a full intravenous dose?** ❑ Yes ❑ No

DIAGNOSES - check applicable box below:

❑ **Chronic Lymphocytic Leukemia:**

- ❑ Prescriber is an Oncologist

AND

- ❑ Patient has a diagnosis of chronic lymphocytic leukemia

❑ **Diffuse Large B-Cell Lymphoma**:

- ❑ Prescriber is an Oncologist.

AND

- ❑ Patient has a diagnosis of diffuse large B-cell lymphoma.

❑ **Follicular Lymphoma:**

- ❑ Prescriber is an Oncologist

AND

- ❑ Patient has a diagnosis of Follicular lymphoma

AND - please note status below

(continued on next page)

- **Previously untreated:** Rituximab 1,400 mg/hyaluronidase 23,400 units (fixed dose) on day 1 of a 21-day cycle in cycles 2 through 8
- **Maintenance**: rituximab 1,400 mg/hyaluronidase 23,400 units (fixed dose) once every 8 weeks for 12 doses
- **Non-progressing disease following 6 to 8 cycles of first-line CVP chemotherapy**: Rituximab 1,400 mg/hyaluronidase 23,400 units (fixed dose) once weekly for 3 weeks (IV rituximab should be administered in week 1 for a total of 4 weeks of therapy) at 6-month intervals to a maximum of 16 doses.
- **Relapsed or refractory:** Rituximab 1,400 mg/hyaluronidase 23,400 units (fixed dose) once weekly for 3 weeks (IV rituximab should be administered in week 1) for a total of 4 weeks of therapy
- **Relapsed or refractory (retreatment**): Rituximab 1,400 mg/hyaluronidase 23,400 units (fixed dose) once weekly for 3 weeks (IV rituximab should be administered in week 1) for a total of 4 weeks of therapy.

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: ~~3/28/2018; 8/29/2018;~~ **10/8/2018**