OPTIMA HEALTH COMMUNITY 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. **If information provided is NOT complete, correct, or legible, authorization will be delayed**.

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

Medication being provided by a Physician's office ONLY.

❑ **URGENT REVIEW. In checking this box, prescriber attests to the fact that by applying the standard review timeframe may seriously jeopardize the member's life, health, or ability to regain maximum function.**

❑ **STANDARD REVIEW**. In checking this box, the timeframe does **NOT** jeopardize the life or health of the member or the member's ability to regain maximum function and would **NOT** subject the member to severe pain.

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

Drug Form/Strength/Month: _____

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

Diagnosis: _____ **ICD Code:** _____

CLINICAL CRITERIA: Check below **ALL** that apply. **ALL** criteria **must** be met for approval. To support each line checked, **ALL** documentation, including lab results, diagnostics, and/or chart notes, **must** be provided or request will be denied.

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

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

❑ **Chronic Lymphocytic Leukemia:**

❑ Prescriber is an Oncologist

AND

❑ Member has a diagnosis of chronic lymphocytic leukemia

(Continued on next page)

❑ Diffuse Large B-Cell Lymphoma:

- ❑ Prescriber is an Oncologist.

AND

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

❑ Follicular Lymphoma:

- ❑ Prescriber is an Oncologist

AND

- ❑ Member has a diagnosis of Follicular lymphoma

AND (please note status below)

- ❑ **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.*

Member Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by the Pharmacy and Therapeutic Committee**: 1/18/2018
REVISED/UPDATED: ~~5/5/2019;~~ **(Reformatted) 7/24/2019**;