OPTIMA HEALTH COMMUNITY CARE

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. If incomplete, authorization process 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 process will 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 box below that applies:

❑ ***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***

- ❑ **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

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*****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