

# OPTIMA HEALTH PLAN

## 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 1-844-202-5034. 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 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 #:** \_\_\_\_\_

\*Approved by the Pharmacy and Therapeutic Committee: 1/18/2018  
REVISED/UPDATED: 3/28/2018.