

OPTIMA HEALTH PLAN

PHARMACY/MEDICAL PRIOR AUTHORIZATION 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 all information below or 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

(signature on next page)

****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.