Rituxan Hycela

CareFirst Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical*	❑ *Home*	❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital*	❑ *Office*	❑ *Pharmacy*

What is the ICD-10 code? _____

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Carefirst MR C17285-A Rituxan Hycela SGM 2099-A- 01/2025.

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com

Exception Criteria Questions:

A. The preferred products for your patient's health plan are Ruxience and Truxima. Can the patient's treatment be switched to one of the preferred products?

❒ Yes, Ruxience, *Please obtain Form for preferred product and submit for corresponding PA.*

❒ Yes, Truxima, *Please obtain Form for preferred product and submit for corresponding PA.*

❒ No, *Continue to Question B*

B. Did the patient have a documented intolerable adverse event to both preferred products (Ruxience and Truxima)? ***Action Required***: If 'Yes', attach supporting chart note(s)

❒ Yes, *Continue to Question C*

❒ No, *Continue to Question D*

C. Was the documented intolerable adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the reference product and biosimilar products)? ***Action Required***: If 'Yes', attach supporting chart note(s)

❒ Yes, *Continue to Question D*

❒ No, *Skip to Clinical Criteria Questions*

D. Did the patient have a documented inadequate response to both preferred products (Ruxience and Truxima)? ***Action Required***: If 'Yes', attach supporting chart note(s)

❒ Yes, *Skip to Clinical Criteria Questions*

❒ No, *Continue to Question E*

E. Does the patient have a contraindication to both preferred products (Ruxience and Truxima)? ***Action Required***: If 'Yes', attach supporting chart note(s)

❒ Yes, *Continue to Clinical Criteria Questions*

❒ No, *Continue to Clinical Criteria Questions*

Criteria Questions:

1. Is this a request for continuation of therapy with the requested drug?

❒ Yes, *Continue to 2*

❒ No, *Continue to 4*

2. What is the diagnosis?

❒ Diffuse large B-cell lymphoma (DLBCL), CD20 positive, *Continue to 3*

❒ Chronic lymphocytic leukemia (CLL) / Small lymphocytic lymphoma (SLL), CD20 positive, *Continue to 3*

❒ Follicular lymphoma (FL), CD20 positive, *Continue to 3*

❒ Histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma, *Continue to 3*

❒ Castleman's disease (CD), CD20 positive, *Continue to 3*

❒ Extranodal marginal zone lymphoma (gastric and non-gastric MALT lymphoma), CD20 positive, *Continue to 3*

❒ High-grade B-cell lymphoma (including high-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 [double/triple hit lymphoma], high-grade B-cell lymphoma, not otherwise specified), CD20 positive, *Continue to 3*

❒ Mantle cell lymphoma, CD20 positive, *Continue to 3*

❒ Nodal marginal zone lymphoma, CD20 positive, *Continue to 3*

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❒ Primary cutaneous B-cell lymphoma (e.g., cutaneous marginal zone lymphoma or cutaneous follicle center lymphomas), CD20 positive, *Continue to 3*

❒ Post-transplant lymphoproliferative disorder (PTLD), CD20 positive, *Continue to 3*

❒ Splenic marginal zone lymphoma, CD20 positive, *Continue to 3*

❒ Hairy cell leukemia, CD20 positive, *Continue to 3*

❒ Waldenstrom Macroglobulinemia / Lymphoplasmacytic Lymphoma, CD20 positive, *Continue to 3*

❒ Hodgkin lymphoma, nodular lymphocyte-predominant, CD20 positive, *Continue to 3*

❒ Other, please specify. _____, *Continue to 3*

3. Is there evidence of unacceptable toxicity while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

4. What is the diagnosis?

❒ Diffuse large B-cell lymphoma (DLBCL), *Continue to 5*

❒ Chronic lymphocytic leukemia (CLL) / Small lymphocytic lymphoma (SLL), *Continue to 5*

❒ Follicular lymphoma (FL), *Continue to 5*

❒ Histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma, *Continue to 5*

❒ Castleman's disease (CD), *Continue to 5*

❒ Extranodal marginal zone lymphoma (gastric and non-gastric MALT lymphoma), *Continue to 5*
❒ High-grade B-cell lymphoma (including high-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 [double/triple hit lymphoma], high-grade B-cell lymphoma, not otherwise specified), *Continue to 5*

❒ Mantle cell lymphoma, *Continue to 5*

❒ Nodal marginal zone lymphoma, *Continue to 5*
❒ Primary cutaneous B-cell lymphoma (e.g., cutaneous marginal zone lymphoma or cutaneous follicle center lymphomas), *Continue to 5*

❒ Post-transplant lymphoproliferative disorder (PTLD), *Continue to 5*

❒ Splenic marginal zone lymphoma, *Continue to 5*

❒ Hairy cell leukemia, *Continue to 5*

❒ Waldenstrom Macroglobulinemia / Lymphoplasmacytic Lymphoma, *Continue to 5*

❒ Hodgkin lymphoma, nodular lymphocyte-predominant, *Continue to 5*

❒ Other, please specify. _____, *Continue to 5*

5. Does the patient have CD20 positive disease that was confirmed by testing or analysis? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results confirming CD20 protein on the surface of the B-cell.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 6*

❒ No, *Continue to 6*

❒ Unknown, *Continue to 6*

6. Has the patient received at least one full dose of a rituximab product by IV infusion without experiencing severe adverse reactions?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

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Step Therapy Override: Complete if Applicable for the state of Maryland.	Please Circle	
Is the requested drug being used to treat stage four advanced metastatic cancer?	Yes	No
Is the requested drug's use consistent with the FDA-approved indication or the National Comprehensive Cancer Network Drugs & Biologics Compendium indication for the treatment of stage four advanced metastatic cancer and is supported by peer-reviewed medical literature?	Yes	No
Is the requested drug being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?	Yes	No
Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?	Yes	No
Do patient chart notes document the requested drug was ordered with a paid claim at the pharmacy, the pharmacy filled the prescription and delivered to the patient or other documentation that the requested drug was prescribed for the patient in the last 180 days?	Yes	No
Has the prescriber provided proof documented in the patient chart notes that in their opinion the requested drug is effective for the patient's condition?	Yes	No

Step Therapy Override: Complete if Applicable for the state of Virginia.	Please Circle	
Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)?	Yes	No
Does the prescribed dose and quantity fall within the FDA-approved labeling or within dosing guidelines found in the compendia of current literature?	Yes	No
Is the request for a brand drug that has an AB-rated generic equivalent or interchangeable biological product available?	Yes	No
Has the patient had a trial and failure of the AB-rated generic equivalent or interchangeable biological product due to an adverse event (examples: rash, nausea, vomiting, anaphylaxis) that is thought to be due to an inactive ingredient?	Yes	No
Is the preferred drug contraindicated?	Yes	No
Is the preferred drug expected to be ineffective based on the known clinical characteristics of the patient and the prescription drug regimen?	Yes	No
Has the patient tried the preferred drug while on their current or previous health benefit plan and it was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?	Yes	No
Is the patient currently receiving a positive therapeutic outcome with the requested drug for their medical condition?	Yes	No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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