BlueCross BlueShield Federal Employee Program.

RITUXIMAB
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

NOTE: Form must be completed in its **entirety** for processing

Please select medication: ❑**Ruxience (rituximab-pvvr)** ❑**Truxima (rituximab-abbs)**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ❑ Brand ❑ Generic

1. What is the patient's diagnosis?

❑ Chronic Lymphocytic Leukemia (CLL)
❑ Hodgkin's lymphoma
❑ Immune thrombocytopenic purpura
❑ Leptomeningeal metastases
❑ Mature B-cell acute leukemia
❑ Primary central nervous system lymphoma
❑ Refractory autoimmune hemolytic anemia
❑ Steroid refractory chronic graft vs. host disease
❑ Thrombotic thrombocytopenic purpura
❑ Waldenström's macroglobulinemia

❑ Granulomatosis w/polyangiitis (formerly Wegener's granulomatosis)
a. Is the patient currently taking a glucocorticoid? ❑Yes ❑No

❑ Microscopic polyangiitis (MPA)
a. Is the patient currently taking a glucocorticoid? ❑Yes ❑No

❑ Myastenia gravis (MG)
a. Does the patient have refractory myasthenia gravis (MG)? ❑Yes ❑No
b. Has the patient been on this medication continuously for the last **6 months**, excluding samples? ❑Yes ❑No*
***If NO,** does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least **TWO** conventional therapies for MG (e.g., corticosteroids, azathioprine, mycophenolate, cyclosporine, methotrexate, tacrolimus, cyclophosphamide, etc.)? ❑Yes ❑No

❑ Non-Hodgkin Lymphoma (NHL)
a. Does the patient have B-cell non-Hodgkin lymphoma? ❑Yes ❑No*
***If NO,** please specify: _____
b. Which type of leukemia/lymphoma does the patient have? ***Please select one of the following below:***

❑AIDS-related B-cell lymphomas
❑Burkitt lymphoma
❑Burkitt-like lymphoma
❑Castleman's disease
❑Diffuse Large B-Cell Lymphoma (DLBCL)
❑Follicular lymphoma
❑Gastric MALT lymphoma
❑Hairy cell leukemia
❑Mantle cell lymphoma
❑Nodal marginal zone lymphoma
❑Non-gastric MALT lymphoma
❑Post-transplant lymphoproliferative disorder
❑Primary cutaneous B-cell lymphoma
❑Splenic marginal zone lymphoma
❑Other type ***(please specify)***: _____

c. Is the leukemia/lymphoma CD20-positive? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES AND QUESTIONS

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑ Pemphigus vulgaris (PV)

a. Has the patient been on this medication continuously for the last **6 months** excluding samples? ❑Yes ❑No*****

If NO, does the patient have moderate to severely active pemphigus vulgaris (PV)? ❑Yes ❑No

❑ Rheumatoid arthritis (RA)

a. Has the patient been on this medication continuously for the last **6 months** excluding samples? ❑Yes ❑No*****

If NO, please answer the following questions:

i. Does the patient have moderate to severely active rheumatoid arthritis (RA)? ❑Yes ❑No

ii. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to one or more tumor necrosis factor (TNF) antagonist therapies? ❑Yes ❑No

❑ Systemic lupus erythematosus (SLE)

a. Does the patient have refractory systemic lupus erythematosus (SLE)? ❑Yes ❑No

❑ Other **(*please specify*):** _____

2. Has the patient been on this medication continuously for the last **6 months** excluding samples? ❑Yes ❑No*****

If NO, does the patient have an intolerance or contraindication or have they had an inadequate treatment response to **ONE** of the following medications: Riabni, Rituxan, or Rituxan Hycela? ❑Yes ❑No

3. Will the patient be given either live or non-live vaccines while on therapy? ***Please select answer below:***

❑Live vaccines ❑Non-live vaccines ❑Live and non-live vaccines ❑No vaccines will be administered

4. **If Non-Live Vaccines**: Will non-live vaccines be administered at least 4 weeks prior to a course of the requested therapy? ❑Yes ❑No

5. Does the patient have any active bacterial, invasive fungal, viral, and other opportunistic infections? ❑Yes ❑No

6. Will this medication be used in combination with another biologic *****DMARD or targeted synthetic DMARD? ❑Yes***** ❑No

If YES, please specify the medication: _____

****DMARDs: Actemra, Avsola, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR***

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***