Rituxan (for Maryland only)

Prior Authorization Request

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

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 **1-866-814-5506.** 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.

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

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

Additional Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*ft* _____*inches*

Criteria Questions:

1. Has the patient been diagnosed with any of the following?
   - ❑ Moderately to severely active rheumatoid arthritis (RA)
   - ❑ Relapsing-remitting multiple sclerosis (RRMS)
   - ❑ Chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL)
   - ❑ Non-Hodgkin's lymphoma (NHL)
   - ❑ Wegener's granulomatosis (also known as granulomatosis with polyangiitis) or microscopic polyangiitis
   - ❑ Acute lymphoblastic leukemia (ALL)
   - ❑ Autoimmune hemolytic anemia
   - ❑ Chronic graft versus host disease
   - ❑ Hodgkin's lymphoma
   - ❑ Idiopathic thrombocytopenic purpura (ITP), relapsed or refractory
   - ❑ Leptomeningeal metastases from lymphomas
   - ❑ Prevention of Epstein-Barr virus (EBV) related post transplant lymphoproliferative disorder (PTLD)
   - ❑ Primary central nervous system (CNS) lymphoma
   - ❑ Sjögren syndrome
   - ❑ Thrombotic thrombocytopenic purpura (TTP)
   - ❑ Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma (LPL)
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Would the prescriber like to request an override of the step therapy requirement? ❑ Yes ❑ No *If No, skip to #6*
4. Has the member received the medication through a pharmacy or medical benefit within the past 180 days?
   ❑ Yes ❑ No ***Action Required*: If Yes, please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e. PBM medication history, pharmacy receipt, EOB etc.)**
5. Is the medication effective in treating the member's condition?
   ❑ Yes ❑ No *Continue to #6 and complete this form in its entirety.*

6. Prior to initiating therapy, has the patient been screened for hepatitis B virus infection with serologic assays?
   ❑ Yes ❑ No

Complete the following section(s) based on the patient's diagnosis.

Section A: Oncology Related Indications

7. Has testing or analysis been performed to identify the CD20 protein on the surface of the B-cell? ❑ Yes ❑ No
   ACTION REQUIRED: Attach a copy of the CD20 protein test results.

8. Is the cancer CD20 positive? ❑ Yes ❑ No

Section B: Hodgkin's Lymphoma

9. What is the Hodgkin's lymphoma subtype? ❑ Lymphocyte predominant ❑ Classical

Section C: Acute Lymphoblastic Leukemia (ALL)

10. Will Rituxan be used as a component of a chemotherapy regimen? ❑ Yes ❑ No

Section D: Non-Hodgkin's Lymphoma

11. What is the subtype of NHL?
    ❑ Follicular lymphoma, *no further questions*
    ❑ Diffuse large B-cell lymphoma (DLBCL), *no further questions*
    ❑ Chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), *no further questions*
    ❑ Mantle cell lymphoma, *no further questions*
    ❑ Burkitt lymphoma
    ❑ Hairy cell leukemia, relapsed or refractory, *no further questions*
    ❑ AIDS-related B-cell lymphoma, *no further questions*
    ❑ Marginal zone lymphoma (splenic or MALT), *no further questions*
    ❑ Primary cutaneous B-cell lymphoma, *no further questions*
    ❑ Post-transplant lymphoproliferative disorder (PTLD), *no further questions*
    ❑ Castleman's disease, *no further questions*
    ❑ Lymphoblastic lymphoma, *no further questions*
    ❑ Other _____

12. Will Rituxan be used as a component of a chemotherapy regimen? ❑ Yes ❑ No

Section E: Rheumatoid Arthritis

13. Has the patient received at least one dose of Rituxan in a paid claim through a pharmacy or medical benefit in the previous 180 days? ❑ Yes - *Specify # of doses:* _____ *If one dose, skip to #18* ❑ No *If No, skip to #15*

14. CONTINUATION ONLY – *If patient has received at least two doses of Rituxan,* has the patient achieved or maintained positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms of RA? *If Yes, skip to #18* ❑ Yes ❑ No

15. Has the patient received any of the following medications in a paid claim through a pharmacy or medical benefit in the previous 120 days? ***If Yes, specify the most recent medication and skip to #18.***
    ❑ Actemra ❑ Cimzia ❑ Enbrel ❑ Humira ❑ Kineret ❑ Orencia
    ❑ Remicade ❑ Inflectra ❑ Simponi ❑ Simponi Aria ❑ Xeljanz ❑ Xeljanz XR
    ❑ No

16. Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate?
    ❑ Yes ❑ No *If No, skip to #19*

17. What was the maximum titrated methotrexate dose? _____ mg per week

18. Is Rituxan being prescribed in combination with methotrexate? ❑ Yes ❑ No

19. Has the patient experienced intolerance to methotrexate **OR** have a contraindication to methotrexate?
    ❑ Intolerance
    ❑ Contraindication, ***Indicate contraindication:*** _____
    ❑ None of the above

20. Is the planned date of administration at least 16 weeks after the date of the last dose received? ❑ Yes ❑ No

Section F: Relapsing-Remitting Multiple Sclerosis

21. Has the patient had an inadequate response to **two or more** disease-modifying drugs indicated for multiple sclerosis despite adequate duration of treatment? ❑ Yes ❑ No
    If Yes, indicate drugs: _____

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)**