Rituxan Hycela

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 1-866-249-6155**. 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.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: ______________________________ **Date**: __________________________________
Patient's ID: ________________________________ **Patient's Date of Birth:** ________________
Physician's Name: ____________________________ **NPI#:** __________________________________
Specialty: __________________________________ **HPHC Provider ID#:**____________________
Physician Office Telephone: __________________ **Physician Office Fax:** ___________________

<u>Rendering</u> Provider Info: ❑ Same as Requesting Provider
Name: ____ **NPI#:** _______________________________
Fax: ______________________ **Phone:** __________________ **HPHC Provider ID:** __________________

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

<u>Additional Demographic Information:</u>

Please indicate the place of service for the requested drug:

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

<u>Drug Information:</u>

*Strength/Measure*______________________________ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_________________________________ *Route of administration*________________________
*Dosing frequency*______________________________

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-844-851-0882

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. Rituxan Hycela HPHC – 10/2018.

Criteria Questions:

1. What is the diagnosis?
   ❑ Diffuse large B-cell lymphoma (DLBCL)
   ❑ Chronic lymphocytic leukemia (CLL)/Small lymphocytic lymphoma (SLL)
   ❑ Follicular lymphoma (FL)
   ❑ Acquired immune deficiency syndrome (AIDS)-related B-cell lymphoma
   ❑ Burkitt lymphoma
   ❑ Castleman's disease (CD)
   ❑ Gastric MALT lymphoma
   ❑ Mantle cell lymphoma
   ❑ Nodal marginal zone lymphoma
   ❑ Nongastric MALT lymphoma
   ❑ Primary Cutaneous B-cell lymphoma (e.g., Cutaneous Marginal Zone lymphoma or Cutaneous Follicle Center lymphomas)
   ❑ Post-transplant lymphoproliferative disorder (PTLD)
   ❑ Splenic marginal zone lymphoma
   ❑ Other ____

2. What is the ICD-10 code? ____________

3. Has testing or analysis been performed which identifies the CD20 protein on the surface of the B-cell?
   ❑ Yes ❑ No ❑ Not applicable, patient's diagnosis is CLL or SLL.

4. Has the patient received at least one full dose of a rituximab product by **IV infusion** without experiencing severe adverse reactions? ❑ 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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