Rituxan

Prior Authorization Request

CVS Caremark administers the medical drug prior authorization program on behalf of Harvard Pilgrim Health Care. Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to CVS Caremark, toll-free at 1-844-851-0882** to initiate the review process. If you have questions regarding the prior authorization please contact CVS Caremark at **1-844-387-1435.**

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:** _____

Rendering 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.

Additional Demographic Information:

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*

Drug Information:

*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un

*Directions(sig)*_____ *Route of administration*_____

*Dosing frequency*_____

Criteria Questions:

1. What is the ICD-10 code?_____

2. What is the diagnosis? *List continues on next page*
   - ❑ Rheumatoid arthritis(RA) *Skip to #9*
   - ❑ Multiple sclerosis (MS) *Skip to #28*
   - ❑ Chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL) *Skip to #6*
   - ❑ Non-Hodgkin's lymphoma (NHL)
   - ❑ Wegener's granulomatosis (granulomatosis with polyangiitis) or microscopic polyangiitis *Skip to#8*
   - ❑ Acute lymphoblastic leukemia (ALL) *Skip to #4*
   - ❑ Autoimmune hemolytic anemia *Skip to #8*
   - ❑ Chronic graft versus host disease *Skip to #8*
   - ❑ Hodgkin's lymphoma *Skip to #5*
   - ❑ Idiopathic thrombocytopenic purpura (ITP), relapsed or refractory *Skip to #8*
   - ❑ Leptomeningeal metastases from lymphomas *Skip to #6*
   - ❑ Prevention of Epstein-Barr virus (EBV) related post transplant lymphoproliferative disorder (PTLD) *Skip to #8*
   - ❑ Primary central nervous system (CNS) lymphoma *Skip to #6*

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❑ Sjögren syndrome Skip to #8
❑ Thrombotic thrombocytopenic purpura (TTP) *Skip to #8*
❑ Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma (LPL) *Skip to #6*
❑ Other _____

3. What is the subtype of NHL? *After answering, skip to #6*
❑ Follicular lymphoma
❑ Diffuse large B-cell lymphoma (DLBCL)
❑ Chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL)
❑ Mantle cell lymphoma
❑ Burkitt lymphoma
❑ Hairy cell leukemia, relapsed or refractory
❑ AIDS-related B-cell lymphoma
❑ Marginal zone lymphoma (splenic or MALT)
❑ Primary cutaneous B-cell lymphoma
❑ Post-transplant lymphoproliferative disorder (PTLD)
❑ Castleman's disease
❑ Lymphoblastic lymphoma
❑ Other _____

4. Will Rituxan be used as a component of a chemotherapy regimen? ❑ Yes ❑ No *Skip to #6*

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

6. Has testing or analysis been performed to identify the CD20 protein on the surface of the B-cell? ***Please attach a copy of the CD20 protein test result.*** ❑ Yes ❑ No

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

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

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Rheumatoid Arthritis

9. Has the patient been diagnosed with moderately to severely active rheumatoid arthritis (RA)? ❑ Yes ❑ No

10. 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 ❑ No *If No, Skip to #13*

11. How many doses in total has the patient received since starting treatment with Rituxan?
❑ 1 dose *Skip to #27*
❑ 2 doses (one complete course) or more

12. 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 #27* ❑ Yes ❑ No

13. 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, please indicate the most recent medication**

❑ Actemra *Skip to #19*	❑ Cimzia *Skip to #19*
❑ Enbrel *Skip to #19*	❑ Humira *Skip to #19*
❑ Inflectra *Skip to #19*	❑ Kineret *Skip to #19*
❑ Orencia *Skip to #19*	❑ Remicade *Skip to #19*
❑ Simponi *Skip to #19*	❑ Simponi Aria *Skip to #19*
❑ Xeljanz *Skip to #19*	❑ Xeljanz XR *Skip to #19*

❑ No

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

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

16. Has the patient experienced intolerance to methotrexate? *If Yes, skip to #19* ❑ Yes ❑ No

17. Does the patient have a contraindication to methotrexate? ❑ Yes ❑ No

18. Please indicate the contraindication.
_____

19. Has the patient previously received treatment with Remicade or Simponi Aria for rheumatoid arthritis?
❑ Yes ❑ No *If No, Skip to #21*

20. Has the patient experienced any of the following during treatment with Remicade or Simponi Aria? ***If yes, please attach supporting documentation***.
❑ Yes – Inadequate response
❑ Yes – Intolerable adverse event (e.g., hypersensitivity reaction)
❑ No

21. Does the patient have a contraindication to Remicade or Simponi Aria? ***If yes, please attach supporting documentation***.❑ Yes ❑ No

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

23. Is Rituxan being prescribed in combination with methotrexate? *If Yes, skip to #27* ❑ Yes ❑ No

24. Has the patient experienced intolerance to methotrexate? *If Yes, skip to #27* ❑ Yes ❑ No

25. Does the patient have a contraindication to methotrexate? ❑ Yes ❑ No

26. Please indicate the contraindication.
_____

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

Section B: Multiple Sclerosis

28. Has the patient been diagnosed with relapsing-remitting multiple sclerosis (RRMS)? ❑ Yes ❑ No

29. 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

30. Which MS medications has the patient had an inadequate response to despite an adequate duration of treatment?
_____

31. Prior to initiating therapy, has the patient been screened for hepatitis B virus infection with serologic assays?
❑ 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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