Rituxan

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.

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: _____
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* ❑ *Inpatient Hospital* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Criteria Questions:

1. Has the patient been diagnosed with any of the following? *List continues on next page.*

Non-Oncology

- ❑ Rheumatoid arthritis (RA)
- ❑ Multiple sclerosis (MS)
- ❑ Wegener's granulomatosis (also known as granulomatosis with polyangiitis) or microscopic polyangiitis
- ❑ Idiopathic thrombocytopenic purpura (ITP), refractory
- ❑ Sjögren syndrome
- ❑ Autoimmune hemolytic anemia
- ❑ Thrombotic thrombocytopenic purpura (TTP)
- ❑ Myasthenia gravis
- ❑ Chronic graft versus host disease
- ❑ Prevention of Epstein-Barr virus (EBV) related post transplant lymphoproliferative disorder (PTLD)
- ❑ Neuromyelitis optica (Devic disease)
- ❑ Polymyositis, refractory
- ❑ Dermatomyositis, refractory
- ❑ Moderate to severe pemphigus vulgaris

Non-Hodgkins Lymphoma (NHL)

- ❑ Diffuse large B-cell lymphoma (DLBCL), CD20 positive
- ❑ Chronic lymphocytic leukemia (CLL), CD20 positive
- ❑ Small lymphocytic lymphoma (SLL), CD20 positive
- ❑ Follicular lymphoma, CD20 positive
- ❑ Mantle cell lymphoma, CD20 positive
- ❑ Marginal zone lymphoma (nodal, splenic, or gastric/non-gastric MALT), CD20 positive
- ❑ Burkitt lymphoma, CD20 positive
- ❑ Castleman's disease, CD20 positive
- ❑ AIDS-related B-cell lymphoma, CD20 positive
- ❑ Primary cutaneous B-cell lymphoma, CD20 positive
- ❑ Hairy cell leukemia, relapsed or refractory, CD20 positive
- ❑ Post-transplant lymphoproliferative disorder (PTLD), CD 20 positive
- ❑ Lymphoblastic lymphoma, CD20 positive

Other Oncology

- ❑ Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma (LPL), CD20 positive
- ❑ Hodgkin's lymphoma, nodular lymphocyte-predominant, CD20 positive
- ❑ Primary central nervous system (CNS) lymphoma, CD20 positive
- ❑ Leptomeningeal metastases from lymphomas, CD20 positive
- ❑ Acute lymphoblastic leukemia (ALL), CD20 positive
- ❑ Immune Checkpoint Inhibitor-related toxicities
- ❑ Other _____

2. What is the ICD-10 code? _____

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

Section A: Rheumatoid Arthritis

3. Has the patient been diagnosed with moderately to severely active rheumatoid arthritis? ❑ Yes ❑ No

4. Is this request for continuation of therapy? ❑ Yes ❑ No *If No, skip to #8*

5. Is the patient currently receiving Rituxan through samples or a manufacturer's patient assistance program?
   ❑ Yes ❑ No ❑ Unknown *If Yes or Unknown, skip to #8*

6. How many doses in total has the patient received since starting treatment with Rituxan? _____
   If one dose, skip to #10.

7. Has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of RA since starting treatment with Rituxan?
   If Yes, skip to #10 ❑ Yes ❑ No

8. Has the patient received any of the following medications?
   If Yes, please indicate the most recent medication and skip to #10.
   ❑ Actemra ❑ Cimzia ❑ Enbrel ❑ Humira ❑ Inflectra ❑ Kevzara ❑ Kineret ❑ Olumiant
   ❑ Remicade ❑ Renflexis ❑ Simponi ❑ Simponi Aria ❑ Xeljanz ❑ Xeljanz XR ❑ No

9. Has the patient experienced an inadequate response after at least 3 months of treatment with the methotrexate dose greater than or equal to 20 mg per week? ❑ Yes ❑ No

10. Is Rituxan being prescribed in combination with methotrexate? *If Yes, skip to #13* ❑ Yes ❑ No

11. Has the patient experienced intolerance to methotrexate? *If Yes, skip to #13* ❑ Yes ❑ No

12. Does the patient have a contraindication to methotrexate? ❑ Yes ❑ No
    If Yes, indicate contraindication: _____

13. Is the planned date of administration at least 16 weeks after the date of the last dose received?
    ❑ Yes ❑ No ❑ Not applicable - Patient has not received any previous dose

Section B: Relapsing-Remitting Multiple Sclerosis

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

15. 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)**