AvMed

PHARMACY/MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-877-535-1391**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization will be delayed**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Drug Requested: Rituxan Hycela® (rituximab and hyaluronidase) **(J9311) (Medical)**

Medication being provided by a Physician's office ONLY.

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

All members must receive at least **one full dose of intravenous rituximab** (without experiencing severe adverse reactions) **PRIOR** to initiating treatment with subcutaneous rituximab/hyaluronidase; members who do not tolerate a full IV dose should continue to receive IV rituximab in subsequent cycles. Member may be switched to subcutaneous rituximab/hyaluronidase injection **AFTER** a full IV dose has been successfully administered.

- **Has Member successfully received a full intravenous dose?** ❑ **Yes** ❑ **No**

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CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ Diagnosis - Chronic Lymphocytic Leukemia:

- ❑ Prescriber is an Oncologist

AND

- ❑ Member has a diagnosis of chronic lymphocytic leukemia

❑ Diagnosis - Diffuse Large B-Cell Lymphoma:

- ❑ Prescriber is an Oncologist.

AND

- ❑ Member has a diagnosis of diffuse large B-cell lymphoma.

❑ Diagnosis - Follicular Lymphoma:

- ❑ Prescriber is an Oncologist

AND

- ❑ Member has a diagnosis of Follicular lymphoma

AND (please note status below)

- ❑ **Previously untreated:** Rituximab 1,400 mg/hyaluronidase 23,400 units (fixed dose) on day 1 of a 21-day cycle in cycles 2 through 8
- ❑ **Maintenance**: rituximab 1,400 mg/hyaluronidase 23,400 units (fixed dose) once every 8 weeks for 12 doses
- ❑ **Non-progressing disease following 6 to 8 cycles of first-line CVP chemotherapy**: Rituximab 1,400 mg/hyaluronidase 23,400 units (fixed dose) once weekly for 3 weeks (IV rituximab should be administered in week 1 for a total of 4 weeks of therapy) at 6-month intervals to a maximum of 16 doses
- ❑ **Relapsed or refractory:** Rituximab 1,400 mg/hyaluronidase 23,400 units (fixed dose) once weekly for 3 weeks (IV rituximab should be administered in week 1) for a total of 4 weeks of therapy
- ❑ **Relapsed or refractory (retreatment**): Rituximab 1,400 mg/hyaluronidase 23,400 units (fixed dose) once weekly for 3 weeks (IV rituximab should be administered in week 1) for a total of 4 weeks of therapy

For urgent reviews: Practitioner should call AvMed Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. AvMed's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****