Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Rituxan Hycela
(rituximab; hyaluranidase)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed**		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Rituxan Hycela 1400mg-23400 units vial
☐ Rituxan Hycela 1600mg-26800 units vial

Dose and quantity: Duration of therapy: J-code:

Frequency of administration: ICD10:

Has your patient already received at least one intravenous (IV) dose of Rituxan? ☐ Yes ☐ No

Is this a new start or continuation of therapy? ☐ New start ☐ continuation of therapy:

(if continued therapy) How many doses of Rituxan Hycela has your patient received to date?

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting*

Is this infusion occurring in a facility affiliated with hospital outpatient setting? ☐ Yes ☐ No

If yes- Is this patient a candidate for re-direction to an alternate setting (such as AIS, MDO, home) with assistance of a Specialty Care Option Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use:

☐ AIDS-related B-cell lymphoma
☐ Burkitt Lymphoma
☐ Castleman's Disease (CD) (giant lymph node hyperplasia, angiofollicular lymph node hyperplasia)
☐ chronic lymphocytic leukemia (CLL)
☐ diffuse large B-cell lymphoma (DLBCL)

☐ follicular lymphoma (FL)
☐ gastric MALT lymphoma
☐ hairy cell leukemia (HCL)
☐ high grade B- cell lymphoma
☐ histologic transformation from marginal zone lymphoma (MZL) to diffuse large B-cell lymphoma (DLBCL)
☐ mantle cell lymphoma (MCL)
☐ nodal marginal zone lymphoma (NMZL)
☐ non-gastric MALT lymphoma
☐ post-transplant lymphoproliferative disorder (PTLD)
☐ primary cutaneous B-cell lymphoma (PCBL)
☐ splenic marginal zone lymphoma (SMZL)
☐ other (please specify:)

(if other) Is the requested drug being used for the treatment of a malignancy? ☐ Yes ☐ No

Clinical Information:

*****This drug requires supportive documentation (chart notes, lab/test results, etc). Supportive documentation for all answers must be attached with this request.*****

(if CLL) Is Rituxan Hycela going to be used in combination with fludarabine (Fludara) and cyclophosphamide (Cytoxan)? ☐ Yes ☐ No

(if DLBCL) Has your patient received any other chemotherapy before for this diagnosis? ☐ Yes ☐ No
(if DLBCL) Is Rituxan Hycela going to be used in combination with CHOP chemotherapy regimen or anthracycline-based chemotherapy? ☐ Yes ☐ No
(if DLBCL and previously treated) Will Rituxan Hycela be used as single-agent therapy? ☐ Yes ☐ No
(if DLBCL and previously treated) Does your patient have relapsed or refractory disease? ☐ Yes ☐ No

(if FL) Which of the following best describes how Rituxan Hycela is being used in your patient?
☐ in combination with first-line chemotherapy
☐ as maintenance therapy
☐ for the treatment of relapsed or refractory disease
☐ other/unknown

(if maintenance therapy) Did your patient have a partial or complete response to first-line treatment with rituximab (Rituxan, Rituxan Hycela) in combination with chemotherapy? ☐ Yes ☐ No
(if no) Is Rituxan Hycela being used after first line treatment with CVP (cyclophosphamide [Cytoxan], vincristine [Oncovin, Vincasar PFS], and prednisone) regimen? ☐ Yes ☐ No
(if yes) Does your patient have stable (not progressing) disease? ☐ Yes ☐ No

(if relapsed or refractory) Is Rituxan Hycela being used as retreatment therapy in this patient? ☐ Yes ☐ No

(if maintenance therapy or relapsed/refractory disease) Will Rituxan Hycela be used as single-agent therapy? ☐ Yes ☐ No

(if AIDS-related B-cell lymphoma, Burkitt, high grade B-cell lymphoma, histologic transformation, MALT lymphoma, MCL, NMZL, PTLD, or SMZL) Which describes how Rituxan Hycela will be used in your patient?
☐ It will be used as single agent therapy.
☐ It will be used in combination with other chemotherapy drugs
☐ unknown
(if single agent) Does your patient have relapsed or refractory disease? ☐ Yes ☐ No
(if in combo with other chemo) Has your patient received any type of chemotherapy before for this diagnosis? ☐ Yes ☐ No

(if AIDS-related B-cell lymphoma, Burkitt, CD, HCL, high grade B-cell lymphoma, histologic transformation, MALT lymphoma, MCL, NMZL, PCBCL, PTLD, or SMZL) Is Rituxan Hycela being used for maintenance therapy? ☐ Yes ☐ No

(if new start) The alternatives (all may require prior authorization) are: 1. Riabni (rituximab-arrx); 2. Ruxience (rituximab-pvvr); 3. Truxima (rituximab-abbs). For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any significant allergies or serious adverse reactions your patient experienced. For the alternatives NOT tried, please provide details why your patient can't try that drug.

For Riabni (rituximab-arrx), which of the following applies to your patient?
☐ Patient has not tried this medication.
☐ Patient tried this medication, but it didn't work or didn't work well enough.
☐ Patient tried this medication, but had an allergic or adverse reaction.
☐ Other

(if allergic response) Is there documentation that this reaction was due to a formulation difference in the inactive ingredients between the requested medication and Riabni (for example, difference in dyes, fillers, preservatives)? ☐ Yes ☐ No

(if yes) Please provide details to support

For Ruxience (rituximab-pvvr), which of the following applies to your patient?
☐ Patient has not tried this medication.
☐ Patient tried this medication, but it didn't work or didn't work well enough.
☐ Patient tried this medication, but had an allergic or adverse reaction.
☐ Other

(if allergic response) Is there documentation that this reaction was due to a formulation difference in the inactive ingredients between the requested medication and Ruxience (for example, difference in dyes, fillers, preservatives)? ☐ Yes ☐ No

(if yes) Please provide details to support

For Truxima (rituximab-abbs), which of the following applies to your patient?
☐ Patient has not tried this medication.
☐ Patient tried this medication, but it didn't work or didn't work well enough.
☐ Patient tried this medication, but had an allergic or adverse reaction.
☐ Other

(if allergic response) Is there documentation that this reaction was due to a formulation difference in the inactive ingredients between the requested medication and Truxima (for example, difference in dyes, fillers, preservatives)? ☐ Yes ☐ No

(if yes) Please provide details to support

Additional Information *(including disease stage, prior therapy [all details regarding any adverse effects, etc.], performance status, and names/doses/admin schedule of any agents to be used concurrently):*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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