SENDERO HEALTH PLANS

Prior Authorization Request Form	**Rituximab**
Sendero Fax: 512-901-9724	**Phone:** 855-297-9191
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)**

Provider Information	**Patient Information**
Referring/Prescribing Physician: ☐ **PCP** ☐ **Specialist** **Name:** **Please identify SPECIALTY:** **DEA, NPI or TIN:** **Contact:** **Phone: ( ) Fax: ( )**	**Patient's Name:** **Birth Date:** **ID Number:** **Phone Number:** **Patient Height:** **Patient Weight:**
Indicate where the drug is being DISPENSED	**Indicate where the drug is being ADMINISTERED**
☐ **Ambulatory Surgery Center** ☐ **Home Care Agency** ☐ **Inpatient Hospital** ☐ **Long Term Care** ☐ **Outpatient Hospital** ☐ **Patient's Home** ☐ **Pharmacy** ☐ **Physician's Office** ☐ **Other (explain):**	☐ **Ambulatory Surgery Center** ☐ **Inpatient Hospital** ☐ **Long Term Care** ☐ **Outpatient Hospital** ☐ **Patient's Home** ☐ **Pharmacy** ☐ **Physician's Office** ☐ **Other (explain):** **Anticipated Date of Service:**

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

PATIENT CLINICAL INFORMATION

CRITERIA QUESTIONS:

1. Is the product being requested for the treatment of an ADULT patient (18 years of age or older) with one of the following indications?

☐ Oncologic conditions (e.g, lymphoma/leukemia)
☐ Benign hematologic conditions (e.g, immune mediated thrombocytopenic purpura)
☐ Neurologic conditions(e.g., neuromyelitis optica spectrum disorders, multiple sclerosis)
☐ Pemphigus vulgaris
☐ Rheumatoid arthritis (RA)
☐ Granulomatosus with polyangiitis (GPA) or microscopic polyangiitis (MPA) – pediatric patients >2yo included
☐ Other: _____

2. What is the prescribed drug?
   Preferred: ☐ **Ruxience** ☐ **Truxima**
   Non-preferred: ☐ Rituxan

3. What is the HCPCS code? _____ What is the ICD-10 code? _____
   What is the NDC#: _____

4. Will the requested drug be used in combination with any other biologic or targeted synthetic DMARD (e.g., Olumiant, Xeljanz)? ☐ Yes ☐ No

5. Has the patient had a TB screening test (e.g., a tuberculosis skin test [PPD] or an interferon-release assay [IGRA]) within 6 months of initiating therapy? ☐ Yes ☐ No

6. What were the results of the TB screening test? ☐ Positive ☐ Negative

7. Does the patient have latent or active tuberculosis (TB)? ☐ Latent ☐ Active ☐ No/Neither

8. If the patient has latent or active tuberculosis, has treatment been initiated or completed?
☐ Yes - treatment initiated ☐ Yes - treatment completed ☐ No

9. Has the patient had the following hepatitis B screening tests completed within 6 months of initiating therapy?

8a. Hepatitis B surface antigen (HBsAg) ☐ Yes – negative ☐ Yes – positive ☐ No, not yet tested

8b. Hepatitis B core antibody total IgG (HBcAb) ☐ Yes – negative ☐ Yes – positive ☐ No, not yet tested

10. If the patient has either a positive HBsAg or HBcAb test, has hepatitis B DNA PCR (viral load) been tested?
☐ Yes – negative ☐ Yes – positive ☐ No, not yet tested

11. Is the patient currently receiving anti-virals for treatment of hepatitis B infection, or prevention of reactivation of hepatitis B infection? ☐ Yes ☐ No

12. Is this request for continuation of therapy? ☐ Yes ☐ No

13. For continuation of therapy requests, has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms since starting treatment with the requested drug? ☐ Yes ☐ No

14. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? ☐ Yes ☐ No

DIAGNOSIS QUESTIONS: ***Please only complete sections below that are relevant to the patient's diagnosis.***

Section A. RHEUMATOID ARTHRITIS

15. The patient has diagnosis of rheumatoid arthritis and the treatment is prescribed by or in consultation with a rheumatologist. ☐ Yes ☐ No

16. Has the patient previously received a biologic or targeted synthetic DMARD (e.g., Rinvoq, Xeljanz) that is indicated for moderately to severely active rheumatoid arthritis? ☐ Yes ☐ No If Yes, please indicate the drug, duration, response, and intolerance/contraindication if applicable:_____

17. Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate 25mg PO weekly* ? ☐ Yes ☐ No If the methotrexate dose is unable to be increased to 25mg PO weekly, please indicate reason: _____

18. Has the patient experienced intolerance to methotrexate? ☐ Yes ☐ No If Yes, indicate intolerance:
_____

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

* Please note, the preferred class of biologic is a TNF inhibitor (specifically Cimzia), followed by anti-IL-6 therapy (specifically Kevzara). Please consider prescribing 1 of these drugs before rituximab if clinically appropriately. If rituximab is preferred over those agents, please provide additional clinical reasoning documentation here:

Section B: Granulomatosis with polyangiitis (GPA), or microscopic polyangiitis

20. The patient has diagnosis of granulomatosis with polyangiitis (GPA), or microscopic polyangiitis and the treatment is prescribed by or in consultation with a rheumatologist. ☐ Yes ☐ No

Section C: Rheumatologic conditions (other)

21. For which rheumatologic condition is rituximab being requested?
_____

22. Please list all prior therapies used to treat this condition (drug, dose, duration, response, intolerance/contraindication) here:
    _____
    _____
    _____

23. Please list all current therapies used to treat this condition (drug, dose, duration, response, intolerance/contraindication) here:
    _____

Section D. Neurologic conditions

24. For which neurologic condition is rituximab being requested?
    _____

25. Please list all prior therapies used to treat this condition (drug, dose, duration, response, intolerance/contraindication) here:
    _____
    _____
    _____

26. Please list all current therapies used to treat this condition (drug, dose, duration, response, intolerance/contraindication) here:
    _____
    _____
    _____

Section E: Pemphigus vulgaris

27. The patient has diagnosis of pemphigus vulgaris (PV) and the treatment is prescribed by or in consultation with a dermatologist. ☐ Yes ☐ No

28. Please rate the severity of pemphigus vulgaris: ☐ Mild ☐ Moderate ☐ Severe

29. Does the patient have an intolerance/contraindication to high-dose corticosteroids? ☐ Yes ☐ No If Yes, please indicate intolerance/contraindication here: _____

30. Has the patient experienced a disease flare during corticosteroid taper? ☐ Yes ☐ No

Section D: Dermatologic conditions (other)

31. For which dermatologic condition is rituximab being requested?
    _____

32. Please list all prior therapies used to treat this condition (drug, dose, duration, response, intolerance/contraindication) here:
    _____
    _____
    _____

33. Please list all current therapies used to treat this condition (drug, dose, duration, response, intolerance/contraindication) here:
    _____
    _____
    _____

Section E: Benign hematologic conditions

34. For which benign hematologic condition is rituximab being requested?

    _____

35. Please list all prior therapies used to treat this condition (drug, dose, duration, response, intolerance/contraindication) here:

    _____
    _____
    _____

36. Please list all current therapies used to treat this condition (drug, dose, duration, response, intolerance/contraindication) here:

    _____
    _____
    _____

Section F. Oncologic conditions

37. For which oncologic condition is rituximab being requested?

    _____

38. Is the requested medication/regimen prescribed for an FDA-approved indication, or an indication supported by National Comprehensive Cancer Network (NCCN) with a Category 1 or 2A recommendation? ☐ Yes ☐ No

39. Was the medication or entire drug regimen previously authorized by Sendero for this member? ☐ Yes ☐ No

40. Is there evidence to support the patient is benefitting from treatment (e.g. positive clinical response, lack of disease progression)? ☐ Yes ☐ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Sendero Health Plans.	
Prescriber or Authorized Signature	DATE