# Outpatient Medical Injectable Rituximab and Biosimilars Request Form

**Fax to 833-581-1861**

**(Medical Benefit Only)**

Member Name: _____

Member Date of Birth: _____

Member ID (UMI): _____ ☐ Medicare ☐ Commercial*

Ordering/Attending Provider Name: _____ NPI: _____

Ordering/Attending Provider Address: _____

Office Contact: _____ Phone #: _____ Fax #: _____

Servicing Facility/Vendor Name: _____ Facility NPI: _____

Servicing Facility/Vendor Address: _____

Requested Start Date of Service: _____ ICD10 Diagnosis Code(s): _____

**DRUG INFORMATION (*please select one*)**

| **PREFERRED PRODUCTS FOR ONCOLOGY INDICATIONS** | **PREFERRED PRODUCT FOR RHEUMATOID ARTHRITIS** | NON-PREFERRED** |
|---|---|---|
| ☐ Ruxience (Q5119)<br>☐ Riabni (Q5123)<br>☐ Rituxan Hycela* (J9311)<br><br>*Rituxan Hycela policy requires the member to have received at least one full dose of a rituximab product by intravenous infusion | ☐ Ruxience (Q5119)<br>☐ Riabni (Q5123) | ☐ Rituxan (J9312)<br>☐ Truxima (Q5115)<br><br>**Has the member experienced a documented drug therapy failure or intolerance to the preferred products?**<br>**Ruxience: ☐ Yes ☐ No**<br>**Riabni: ☐ Yes ☐ No**<br><br>**A non-preferred product will be considered when the member has a documented drug therapy failure after an adequate therapeutic trial of **BOTH** preferred products, or **BOTH** preferred products have not been tolerated or are contraindicated<br><br>**Medicare members currently established on a non-preferred therapy are not required to try a preferred option. |

****Please verify member's eligibility and benefits through the health plan****

| **Please answer the following for ONCOLOGY indications:** ***(for non-oncology indications please proceed to question 6)*** | |
|---|---|
| 1. What type of cancer does the member have (include histology) and what stage disease? | |
| **2.** What is the member's chemotherapy regimen? | |
| **3.** What line of therapy is this considered (First, Second, Subsequent)? | |
| **4.** What previous therapies has the member received? (Please include if the member progressed or relapsed) | |
| 5. Is the member's disease CD20-positive? | ☐YES ☐NO ☐ NOT APPLICABLE |
| **Please answer the following for a NON-ONCOLOGY indication:** ***(In addition please make sure the accurate icd10 diagnosis code was given above)*** | |
| 6. What medications (if any) has the member previously used for this condition? | |
| 7. What medications (if any) will the member be using in conjunction for the condition? | |
| 8. What is the dose and frequency of the member's treatment? | Dose: _____ Frequency: _____ |
| **For Rheumatoid Arthritis indications ONLY** 9. Is the member's RA moderately to severely active? | ☐YES ☐NO |

| ☐ **New Start** | ☐ **Continuation of Therapy** |
|---|---|
| | Date of last infusion: _____ |
| | **Has the member demonstrated disease stability or a beneficial response to therapy?** ☐ **YES** ☐ **NO** |

**Please attach all pertinent clinical information**

**Attached:** ☐ **YES** ☐ **NO**