HIGHMARK
NORTHEASTERN NEW YORK

Outpatient Medical Injectable Rituximab and Biosimilars Request Form

Fax to 833-619-5745

(Medical Benefit Only)

Member Name: _____

Member Date of Birth: _____

Member UMI: _____ ☐ Medicare ☐ Commercial

Requesting Physician's Name: _____ NPI Number: _____

Requesting Physician's Address: _____

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

Facility: _____ Facility NPI Number: _____

Facility's Address: _____

Date of Service: _____

Diagnosis Code(s): _____

DRUG INFORMATION (*please select one*)

PREFERRED PRODUCTS FOR ONCOLOGY INDICATIONS	**PREFERRED PRODUCT FOR RHEUMATOID ARTHRITIS**	NON-PREFERRED
☐ Ruxience (Q5119) ☐ Riabni (Q5123) ☐ Rituxan Hycela* (J9311) *Rituxan Hycela policy requires the patient to have received at least one full dose of a rituximab product by intravenous infusion	☐ Ruxience (Q5119) ☐ Riabni (Q5123)	☐ Rituxan (J9312) ☐ Truxima (Q5115) **Has the member experienced a documented drug therapy failure or intolerance to the preferred products?** **Ruxience:** ☐ **Yes** ☐ **No** **Riabni:** ☐ **Yes** ☐ **No** *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 *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****

Fax this completed form to Highmark at 1-833-619-5745

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 patient progressed or relapsed)	
5. Is the patient'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: _____
<u>For Rheumatoid Arthritis indications ONLY</u> 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

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

Fax this completed form to Highmark at 1-833-619-5745