

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)	Ruxience (Q5119)	Rituxan (J9312)				
Riabni (Q5123)	☐ Riabni (Q5123)	☐ Truxima (Q5115)				
Rituxan Hycela* (J9311) *Rituxan Hycela policy requires the patient to have received at least one full dose of a rituximab product by intravenous infusion		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**

Please answer the following for ONCOLOGY indications: (for non-oncology indications please proceed to question 6)				
1.	I. What type of cancer does the member have (include histology) and what stage disease?			
2. What is the member's chemotherapy regimen?				
3.	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.	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:	
9.		d Arthritis indications ONLY 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**