



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

Rituxan Hycela (rituximab; hyaluronidase)

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:
City:			State:		Zip:
State:			Patient Phone:		
Zip:					
Urgency: <input type="checkbox"/> Standard <input type="checkbox"/> 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: <input type="checkbox"/> Rituxan Hycela 1400mg-23400 units vial <input type="checkbox"/> 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 rituximab? <input type="checkbox"/> Yes <input type="checkbox"/> No Is this a new start or continuation of therapy? <input type="checkbox"/> New start <input type="checkbox"/> continuation of therapy: (if continued therapy) How many doses of Rituxan Hycela has your patient received to date?					
Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Other (please specify): _____ **Cigna's nationally preferred specialty pharmacy					
<i>**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</i>					
Facility and/or doctor dispensing and administering medication: Facility Name: _____ State: _____ Tax ID#: _____ Address (City, State, Zip Code): _____ <p style="text-align: center;">NOTE: Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting</p> Is this infusion occurring in a facility affiliated with hospital outpatient setting? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Diagnosis related to use: <input type="checkbox"/> AIDS-related B-cell lymphoma <input type="checkbox"/> Burkitt Lymphoma <input type="checkbox"/> Castleman's Disease (CD) (giant lymph node hyperplasia, angiofollicular lymph node hyperplasia) <input type="checkbox"/> chronic lymphocytic leukemia (CLL) <input type="checkbox"/> 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)
- All other indications

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 and cyclophosphamide? 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 yes) 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

(if maintenance therapy) Did your patient have a partial or complete response to first-line treatment with rituximab in combination with chemotherapy? Yes No

(if no) Is Rituxan Hycela being used after first line treatment with CVP (cyclophosphamide, vincristine, 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) Will Rituxan Hycela be used as single-agent therapy? Yes No

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

(if relapsed or refractory, 18+ years and not single agent) Will Rituxan Hycela be used in combination with lenalidomide and tafasitamab-cxix? 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

(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, PCBL, PTLD, or SMZL) Is Rituxan Hycela being used for maintenance therapy? Yes No

(if new start) Has the patient tried ALL of the following alternatives: Riabni (rituximab-arrx) [may require prior authorization], Ruxience (rituximab-pvvr) [may require prior authorization], AND Truxima (rituximab-abbs) [may require prior authorization]? Yes No

(if yes) Is the patient unable to continue the use of the alternative(s) due to a formulation difference in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction? Yes No

Additional Information

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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