Blue Cross Blue Shield/Blue Care Network of Michigan
Medication Authorization Request Form

Blue Cross Blue Shield Blue Care Network of Michigan

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This form is to be used by participating physicians to obtain coverage for **drugs covered under the medical benefit**. For commercial members only, please complete this form and submit via fax to 1-877-325-5979. If you have any questions regarding this process, please contact BCBSM Provider Relations and Servicing or the Medical Drug Helpdesk at 1-800-437-3803 for assistance.

PATIENT INFORMATION		PHYSICIAN INFORMATION
Name		**Name**
ID Number		**Specialty**
D.O.B.	_____/_____/_____ MM/DD/YYYY ❑Male ❑Female	**Address**
Diagnosis		**City /State/Zip**
Drug Name	**Riabni, Rituxan**	**Phone:** **Fax:**
Dose and Quantity		**NPI**
Directions		**Contact Person**
Date of Service(s)		**Contact Person** **Phone / Ext.**

STEP 1: DISEASE STATE INFORMATION

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*ft* _____*inches*

Will the provider be administering the medication to the FEP member within the health plan's geographic service area?

❑ Yes ❑ No *If No, a prior authorization is not required through this process*.

Prior authorizations are required for FEP members that will be serviced by a provider within the health plan's geographic service area. If you are not a provider in the geographic service area, please contact the health plan for questions regarding the FEP member's benefit requirements.

Is this member's FEP coverage primary or secondary coverage?

❑ If primary, continue with question set.

❑ If secondary, **an authorization is not needed through this process. Please contact the member's primary coverage for determination of benefit and additional information.**

Criteria Questions:

Please select medication: **❑Rituxan (rituximab)** **❑ Riabni (rituximab-arrx)**

1. Will the patient be given either live or non-live vaccines while on therapy? ***Please select answer below:***

   ❑Live vaccines ❑Non-live vaccines* ❑Both, live and non-live vaccines ❑No vaccines will be administered

   If Non-Live Vaccines, will non-live vaccines be administered at least four weeks prior to a course of Rituxan? ❑Yes ❑No

2. Does the patient have any active bacterial, invasive fungal, viral, and other opportunistic infections? ❑Yes ❑No

3. Will Rituxan be used in combination with any other biologic *DMARD or targeted synthetic DMARD? ❑Yes* ❑No

   If YES, please specify: _____

   DMARD includes: Actemra, Avsola, Cimzia, Cosentyx, Enbrel, Entyvio, Humira, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Renflexis, Rinvoq, Rituxan, Siliq, Simponi/Simponi Aria, Skyrizi, Stelara, Taltz, Tremfya, and Xeljanz

4. What is the patient's diagnosis?

   ❑Chronic Lymphocytic Leukemia (CLL)
   ❑Hodgkin's lymphoma
   ❑Immune thrombocytopenic purpura
   ❑Leptomeningeal metastases
   ❑Mature B-cell acute leukemia
   ❑Primary central nervous system lymphoma
   ❑Refractory autoimmune hemolytic anemia
   ❑Steroid refractory chronic graft vs. host disease
   ❑Thrombotic thrombocytopenic purpura
   ❑Waldenström's macroglobulinemia
   ❑Granulomatosis w/polyangiitis (formerly Wegener's granulomatosis)
      a. Is the patient currently taking a glucocorticoid? ❑Yes ❑No
   ❑Microscopic Polyangiitis (MPA)

a. Is the patient currently taking a glucocorticoid? ❑Yes ❑No

❑ Myasthenia Gravis (MG)

a. Does the patient have refractory myasthenia gravis (MG)? ❑Yes ❑No

b. Has the patient been on Rituxan continuously for the last **6 months**, excluding samples? ❑Yes ❑No*

If NO, does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least **TWO** conventional therapies for MG (e.g., corticosteroids, azathioprine, mycophenolate, cyclosporine, methotrexate, tacrolimus, cyclophosphamide, etc.)? ❑Yes ❑No

❑ Non-Hodgkin Lymphoma (NHL)

a. Does the patient have B-cell non-Hodgkin lymphoma? ❑Yes ❑No*

***If NO*, specify type of lymphoma: _____**

b. What type of lymphoma/leukemia does the patient have? ***Please select one of the following below:***

❑AIDS-related B-cell lymphomas	❑Follicular lymphoma	❑Non-gastric MALT lymphoma
❑Burkitt lymphoma	❑Gastric MALT lymphoma	❑Post-transplant lymphoproliferative disorder
❑Burkitt-like lymphoma	❑Hairy cell leukemia	❑Primary cutaneous B-cell lymphoma
❑Castleman's disease	❑Mantle cell lymphoma	❑Splenic marginal zone lymphoma
❑Diffuse Large B-Cell Lymphoma (DLBCL)	❑Nodal marginal zone lymphoma	

❑Other type ***(please specify)***: _____

c. Is the lymphoma/leukemia CD20-positive? ❑Yes ❑No

❑ Pemphigus Vulgaris (PV)

a. Has the patient been on Rituxan continuously for the last **6 months**, excluding samples? ❑Yes ❑No*

If NO, is the patient's pemphigus vulgaris moderately to severely active? ❑Yes ❑No

❑ Rheumatoid Arthritis (RA)

a. Has the patient been on Rituxan continuously for the last **6 months**, excluding samples? ❑Yes ❑No*

***If NO*, please answer the following questions:**

i. Is the patient's rheumatoid arthritis moderately to severely active? ❑Yes ❑No

ii. Does the patient have a contraindication or have they had either an inadequate response or intolerance to one or more tumor necrosis factor (TNF) antagonist therapies? ❑Yes ❑No

❑ Systemic Lupus Erythematosus (SLE)

a. Does the patient have refractory systemic lupus erythematosus? ❑Yes ❑No

❑ Other diagnosis **(*please specify*): _____**

Chart notes are required for the processing of all requests. Please add any other supporting medical information necessary for our review **(required)**

Coverage will not be provided if the prescribing physician's signature and date are not reflected on this document.

❑ Request for expedited review: I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function

Physician's Name	**Physician Signature**	**Date**
Step 2: Checklist	❑ Form Completely Filled Out ❑ Provide chart notes	❑ Attach test results
Step 3: Submit	**By Fax: BCBSM Specialty Pharmacy Mailbox 1-877-325-5979**	**By Mail: BCBSM Specialty Pharmacy Program P.O. Box 312320, Detroit, MI 48231-2320**