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	**Ruxience, Truxima**	**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: **❑Truxima (rituximab-abbs)** **❑ Ruxience (rituximab-pvvr)**

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. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to one of the preferred medications: Rituxan, Rituxan Hycela, or Riabni? ❑Yes ❑No

5. 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**