OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Rituxan Hycela™ Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			**Provider Information** (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Chronic lymphocytic leukemia
❑ Diffuse large B-cell lymphoma
❑ Follicular lymphoma
❑ Other diagnosis: ____ ICD-10 Code(s): _______________________________________

Clinical Information:

Will the patient receive a full induction dose of intravenous rituximab prior to initiation of therapy? ❑ **Yes** ❑ **No**

Select if Rituxan Hycela is prescribed by or in consultation with one of the following specialists:
❑ Hematologist
❑ Oncologist

For chronic lymphocytic leukemia, also answer the following:

Is Rituxan Hycela being used in combination with fludarabine and cyclophosphamide (FC) therapy? ❑ **Yes** ❑ **No**

For diffuse large B-cell lymphoma, also answer the following:

Was the disease previously untreated? ❑ **Yes** ❑ **No**

Will Rituxan Hycela be used in combination with cyclophosphamide, doxorubicin, vincristine, prednisone (CHOP) or other anthracycline-based chemotherapy? ❑ **Yes** ❑ **No**

For follicular lymphoma, also answer the following:

Does the patient have a follicular CD20-positive lymphoma? ❑ **Yes** ❑ **No**

Is the disease relapsed or refractory? ❑ **Yes** ❑ **No**

Has the patient exhibited complete or partial response to prior treatment with rituximab in combination with chemotherapy? ❑ **Yes** ❑ **No**

Is the patient's disease non-progressing or stable following prior treatment with first-line cyclophosphamide, vincristine, and prednisone (CVP) chemotherapy? ❑ **Yes** ❑ **No**

Was the disease previously untreated? ❑ **Yes** ❑ **No**

Will Rituxan Hycela be used in combination with first-line chemotherapy? ❑ **Yes** ❑ **No**

Reauthorization:

Does the patient show evidence of progressive disease while on Rituxan Hycela therapy? ❑ **Yes** ❑ **No**

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Rituxan Hycela™ Prior Authorization Request Form (Page 2 of 2)

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

____

____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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