

**REVIEW REQUEST FOR
Rituxan® - Oncology**

Provider Data Collection Tool Based on Medical Policy DRUG.00041

Complete form in its entirety and fax to UM Call Center at (404) 848-2448

Policy Last Review Date: 11/17/2011		Policy Effective Date: 01/11/2012		Provider Tool Effective Date: 01/11/2012	
Request Date: / /					
<input type="checkbox"/> Initial Request		<input type="checkbox"/> Subsequent Request			
<input type="checkbox"/> Buy and bill					
Individual's Name:			Date of Birth: / /		
Insurance Identification Number:			Individual's Phone Number:		
Primary Diagnosis:		ICD-9 Code(s) (if known):		Individual's Weight _____ <input type="checkbox"/> (lbs) <input type="checkbox"/> (kg)	
				Individual's Height _____ <input type="checkbox"/> (in) <input type="checkbox"/> (cm)	
Ordering Provider Name & Specialty:			Provider ID Number (if known):		
Office Address:					
Contact Name and Office Phone Number:			Office Fax Number:		
Servicing Provider Name & Specialty (If different than Ordering Provider):			Provider ID Number (if known):		
Office Address:					
Contact Name and Office Phone Number:			Office Fax Number:		
Place of Service: <input type="checkbox"/> Home <input type="checkbox"/> Office <input type="checkbox"/> Dialysis Center <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Ambulatory Infusion <input type="checkbox"/> Ambulatory Infusion Center <input type="checkbox"/> Other: _____					
Drug Name/HCPS Code (if known) <input type="checkbox"/> Rituxan® J9310 <input type="checkbox"/> Other: _____		Dose to be administered: _____ (mg/m2) _____ (mg) _____ (Other)			
When did the individual first start this drug? / /		Frequency (Days, Wks, Months) _____			
Duration: _____ (Weeks)		Start Date For This Request: / /			

Please check all that apply to the individual:

Complete this section before proceeding to the following disease specific sections:

Please check if the individual has been treated with any chemotherapy medications in the past (If checked, provide the chemotherapy medications that the individual has received): _____

1) Chronic lymphocytic Leukemia (CLL)

- Individual has been diagnosed with CD20+ CLL
- Other:

2) Hodgkin's Lymphoma

- Individual has been diagnosed with CD20+ Hodgkin's lymphoma.
- Other:

3) Non-Hodgkin's Lymphoma (NHL)

- Individual has been diagnosed with CD 20+ NHL.
- Rituxan® will be used as maintenance therapy for CD20+ follicular B-cell NHL for no more than 2 years
- Rituxan® will be used as part of Zevalin® regimen for NHL and will be given concurrently with Zevalin®. **Please check any that applies:**
 - Individual has relapsed or refractory low-grade or follicular B-cell NHL
 - Individual with previously untreated follicular NHL who has achieved partial or complete response to first line chemotherapy
 - Other:
- Other:

4) Rheumatoid Arthritis (RA)

- Individual is at least 18 years of age and has been diagnosed with moderately to severely active RA. **Please check any that applies:**
 - Rituxan® will be used in combination with methotrexate
 - Rituxan® will not be used in combination with methotrexate
 - Individual is methotrexate intolerant or it is contraindicated
 - Individual had an inadequate response to one or more Tumor necrosis factor (TNF) antagonist therapies
 - Other:
- Other:

5) Wegener's Granulomatosis (WG) and Microscopic Polyangiitis (MPA)

- Individual has been diagnosed with Wegener's Granulomatosis and microscopic polyangiitis
 - Rituxan® will be used in combination with glucocorticoids
 - Other:

6) Auto Immune Hemolytic Anemia

- Individual has been diagnosed with refractory auto immune hemolytic anemia
- Other:

7) Graft Versus Host Disease (GVHD)

- Individual has been diagnosed with GVHD and Rituxan® will be given as third line of therapy or greater
- Other:

8) Hairy Cell Leukemia

- Individual has been diagnosed with CD20+ Hairy Cell Leukemia
- Other:

9) Multicentric Castleman's disease (MCD)

- Individual has been diagnosed with MCD CD 20+ disease
- Other:

10) Neuromyelitis Optica (NMO)

- Individual has been diagnosed with NMO
- Other:

11) Pemphigus Vulgaris and other Autoimmune Blistering Skin Diseases

- Individual has been diagnosed with refractory pemphigus vulgaris or other autoimmune blistering skin diseases (such as pemphigus foliaceus, bullous pemphigoid, cicatricial pemphigoid, epidermolysis bullosa acquisita, paraneoplastic pemphigus)
- Other:

12) Post-transplant Lymphoproliferative Disease

- Individual has been diagnosed with CD20+ post-transplant lymphoproliferative disease
- Other:

13) Renal Transplant

- Rituxan® will be given pre-transplant to suppress panel reactive anti-HLA antibodies in individual with high panel reactive antibody (PRA) levels to human leukocyte antigens (HLA)
- Rituxan® will be given post-transplant in individual with acute rejection who had received rituximab (Rituxan®) pre-transplant
- Other:

14) Systemic Autoimmune Disorders

- Individual has been diagnosed with a systemic autoimmune disorder (such as cryoglobulinemia, Primary Sjogren Syndrome [SS], Systemic Lupus Erythematosus [SLE]) which is refractory to standard therapy (lack of response to corticosteroids and at least two immunosuppressive agents)
- Other:

15) Thrombocytopenic Purpura

- Individual has been diagnosed with Immune or Idiopathic Thrombocytopenic Purpura (ITP) which is refractory to steroids
- Other:

16) Waldenstrom Macroglobulinemia

- Individual has been diagnosed with Waldenstrom Macroglobulinemia
- Other:

17) Other Use(s) (Please submit all supporting documents including labs, progress notes, imaging, etc., for review.)

This request is being submitted:

Pre-Claim

Post-Claim. If checked, please attach the claim or indicate the claim number _____

I attest the information provided is true and accurate to the best of my knowledge. I understand that the health plan or its designees may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

Name & Title of Provider or Provider Representative Completing Form
& attestation (Please Print)*

/ /
Date

***The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted**

Anthem UM Services, Inc., a separate company, is the licensed utilization review agent that performs utilization management services on behalf of your health benefit plan or the administrator of your health benefit plan.