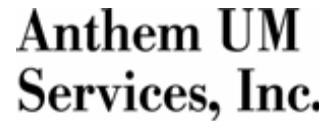


REVIEW REQUEST FOR



**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: 05/21/09	Policy Effective Date: 07/15/09	Provider Tool Effective Date: XX/XX/XX
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Request Date:        /        /		
<input type="checkbox"/> <b>Initial Authorization Request</b>		<input type="checkbox"/> <b>Subsequent Request</b>
<input type="checkbox"/> <b>Buy and bill</b>		
<input type="checkbox"/> Medication(s) is to be dispensed, delivered, and managed by Precision Rx Specialty Solutions (800-824-2642) FAX Ship Medication to: <input type="checkbox"/> MD Office <input type="checkbox"/> Member's Home <input type="checkbox"/> Other: (please specify): _____		
Member Name:		Date of Birth: /        /
Insurance Identification Number:		Member Phone Number:
Primary Diagnosis:	ICD-9 Code(s) (if known):	Member's Weight _____ <input type="checkbox"/> (lbs) <input type="checkbox"/> (kg)
Ordering Provider Name & Specialty:		Provider ID Number (if known):
Office Address:		
<b>Contact Name</b> and Office Phone Number:		Office Fax Number:
Servicing Provider Name & Specialty ( <b>If different than Ordering Provider</b> ):		Provider ID Number (if known):
Office Address:		
<b>Contact Name</b> 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/m <sup>2</sup> )	
When did the member first start this drug? /        /	Frequency (Days, Wks, Months) _____	
Duration: _____ (Weeks)	Start Date For This Request: /        /	

**Please check all that apply to the member:**

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

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

**Please check all that apply to the member:**

**1) Hodgkin's Lymphoma**

Member has been diagnosed with Hodgkin's lymphoma. **If checked please check all of the following that apply:**

Rituxan will be used in the treatment of CD20+ Lymphoma

This will be used as induction therapy

This will be used as re-induction therapy with no relapse within 6 months while on Rituxan

Other:

**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.**

## 2). Non-Hodgkin's Lymphoma

- Member has been diagnosed with Non Hodgkin's Lymphoma
- Rituxan will be used in the treatment of CD20+ Lymphoma
  - This will be used as induction therapy
  - This will be used as re-induction therapy with no relapse within 6 months while on Rituxan
  - This will be used as maintenance therapy for CD20+ follicular B-Cell Non-Hodgkin's Lymphoma for no more than 2 years
- This will be used as part of Zevalin regimen for Non-Hodgkin's Lymphoma. **If checked please check all of the following that apply:**
  - Member has low grade or follicular NHL
  - The disease relapsed or refractory
  - The member has been currently given Zevalin
- Other:

## 3). Chronic Lymphocytic Leukemia

- Member has been diagnosed with CD20+ Chronic Lymphocytic Leukemia (CLL)
- Other:

## 4). Hairy Cell Leukemia

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

## 5). Waldenstrom Macroglobulinemia

- Member has been diagnosed with Waldenstrom Macroglobulinemia. **If checked, please check all of the following that apply:**
  - This will be used as primary treatment as a single agent along with plasmapheresis for symptomatic hyperviscosity
  - This will be used as a follow-up treatment as a single agent for the following indications:
    - Progressive disease or disease relapse in less than 6 months following response to initial treatment with alkylating agents or nucleoside analogs **or**
    - Diseases relapse after 6 months following response to initial treatment with Rituxan, alkylating agents or nucleoside analogs
  - This will be used as palliative treatment as a single agent for progressive disease after second-line therapy
- Other:

## 6). Thrombocytopenic Purpura

- Member has been diagnosed with Immune or Idiopathic Thrombocytopenic Purpura and refractory to steroids
- Member has been diagnosed with Thrombotic Thrombocytopenic Purpura
- Other:

## 7). Rheumatoid Arthritis

- Member has been diagnosed with Rheumatoid Arthritis
- This will be used in combination with methotrexate for moderate to severely active RA. **If checked, please check all of the following that apply:**
- Member has had an inadequate response to one or more TNF antagonist therapies
- Other:

## 8). Auto Immune Hemolytic Anemia

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

## 9). Post-transplant Lymphoproliferative Disease

Member is being treated for CD20+ post-transplant lymphoproliferative disease

Other:

**10). Refractory Autoimmune Blistering Skin Diseases**

Member is being treated for refractory autoimmune blistering skin diseases (Pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, cicatricial pemphigoid, epidermolysis bullosa acquisita, paraaneoplastic pemphigus)

Other:

**11). Systemic Autoimmune Disorders**

The member is being treated for an systemic autoimmune disorder (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:

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

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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 Anthem 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**

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