PriorityHealth

Medicare Part B Step Therapy Form

Fax completed form to: 877 974-4411 toll free, or 616 942-8206

This form applies to: ☒ **Medicare Part B**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Rituxan® (rituximab)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product and Billing Information

☐ New request ☐ Continuation request - **Original therapy start date**: _____

Drug product:

☐ Rituxan 100mg/10ml solution (IV)

☐ Rituxan 500mg/50ml solution (IV)

Date of last dose (if applicable): _____

Date of next dose (if applicable): _____

Dose:_____ **Dose Frequency**:_____

Number of doses requested: _____

HCPCS Code: _____

Place of administration:

☐ Physician's office

☐ Outpatient infusion

Facility: _____ NPI:_____ Fax:_____

☐ Home infusion

Facility: _____ NPI:_____ Fax:_____

Billing:

☐ Physician to buy and bill

☐ Facility to buy and bill

☐ Specialty Pharmacy

Pharmacy:_____ NPI:_____ Fax:_____

ICD-10 Diagnosis code(s): _____

Precertification Requirements

NOTE: Step therapy (trial with the below listed drug(s)) is only applicable to members who are enrolled in an MAPD (Medicare Advantage Prescription Drug) plan.

All fields must be complete and legible for review. Your office will receive a response via fax. Created 01/2019

Before this drug is covered, the patient must meet the following:

1. For dermatomyositis:
   - Must first try a corticosteroid
2. For idiopathic thrombocytopenic purpura:
   - Must first try a corticosteroid
3. For granulomatosis with polyangiitis (MPA):
   - Must first try a corticosteroid and cyclophosphamide
4. For pemphigus vulgaris:
   - Must first try dapsone
5. For rheumatoid arthritis (RA):
   - Must first try one disease-modifying antirheumatic drug (DMARD) and infliximab
6. For myasthenia gravis:
   - Must first try two immunotherapies (e.g. azathioprine, mycophenolate, cyclosporine, tacrolimus)

National and Local Coverage Determination Criteria

Priority Health Medicare applies CMS national coverage determination (NCD) and local coverage determination (LCD) criteria for Part B drugs. If no NCD or LCD criteria are available for the state in which the member is receiving the services, the medication must be being used for a medically-accepted diagnosis as defined in the Medicare Benefit Policy Manual Chapter 15 § 50.

For additional indications and/or criteria not listed on this form, the following NCD and/or LCD criteria apply:

LCD: WPS (Wisconsin Physician Services) L37205: Chemotherapy Drugs and their Adjuncts

Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Non-Hodgkin's lymphoma (NHL)
- ☐ Acute lymphocytic leukemia (ALL)
- ☐ Chronic lymphocitic leukemia (CLL)
- ☐ Hodgkin's lymphoma
- ☐ Waldenstrom's macroglobulinemia
- ☐ Thrombocytopenic purpura, immune or idiopathic *(step therapy required)*
- ☐ Autoimmune hemolytic anemia
- ☐ Rheumatoid arthritis *(step therapy required)*
- ☐ Post stem cell transplant and Epstein Barr virus
- ☐ Graft versus host disease, *only when* disease is steroid-refractory
- ☐ Acute refractory and relapsed refractory thrombotic thrombocytopenic purpura (TTP) due to immune-mediated ADAMTS-13 deficiency
- ☐ Granulomatosis with polyangiitis *(step therapy required)*
- ☐ Post-transplant lymphoproliferative disorder
- ☐ Multicentric Castleman's disease associated with human herpesvirus infection in HIV-infected patients
- ☐ Microscopic polyangiitis (MPA)
- ☐ Dermatomyositis *(step therapy required)*
- ☐ Acquired hemophilia
- ☐ Acquired coagulation factor deficiency
- ☐ Polymyositis
- ☐ Pemphigus vulgaris *(step therapy required)*
- ☐ Relapsing-remitting multiple sclerosis
- ☐ Neuromyelitis optica
- ☐ Myasthenia gravis *(step therapy required)*
- ☐ Other: _____

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Are you asking for an exception to the above list of diagnoses?

☐ Yes. ***Rationale for exception*:** _____

☐ No

B. For dermatomyositis, has the patient tried a corticosteroid?

☐ Yes

☐ No

Are you asking for an exception to this requirement?

☐ Yes. ***Rationale for exception***: _____

☐ No

C. For idiopathic thrombocytopenic purpura, has the patient tried a corticosteroid?

☐ Yes

☐ No

Are you asking for an exception to this requirement?

☐ Yes. ***Rationale for exception***: _____

☐ No

D. For granulomatosis with polyangiitis (MPA), has the patient tried a corticosteroid *and* cyclophosphamide?

☐ Yes

☐ No

Are you asking for an exception to this requirement?

☐ Yes. ***Rationale for exception***: _____

☐ No

E. For pemphigus vulgaris, has the patient tried dapsone?

☐ Yes

☐ No

Are you asking for an exception to this requirement?

☐ Yes. ***Rationale for exception***: _____

☐ No

F. For rheumatoid arthritis (RA)

a. Has the patient tried one disease-modifying antirheumatic drug (DMARD) *and* infliximab?

☐ Yes. Check all that apply:

- ☐ Methotrexate
- ☐ Hydroxychloroquine
- ☐ Leflunomide
- ☐ Sulfasalazine
- ☐ Infliximab

☐ Other: _____

☐ No

Are you asking for an exception to this requirement?

☐ Yes. ***Rationale for exception***: _____

☐ No

b. Will Rituxan be given in combination with methotrexate?

☐ Yes

☐ No

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G. For myasthenia gravis, has the patient tried two immunotherapies?

- ☐ Yes. Check all that apply:
  - ☐ Azathioprine
  - ☐ Mycophenolate
  - ☐ Cyclosporine
  - ☐ Tacrolimus
- ☐ No

Are you asking for an exception to this requirement?

- ☐ Yes. ***Rationale for exception***: _____
- ☐ No

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