



Rituxan Hycela

HMSACOM - Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-237-5512.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414**. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Patient's Phone Number: _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Patient Weight: _____ *kg*
Patient Height: _____ *ft* _____ *inches*

Indicate where the drug is being dispensed:

- Office Outpatient Hospital Ambulatory Surgical Inpatient Hospital
- Off Campus Outpatient Hospital Urgent Care Emergency Room Birthing Center
- Military Facility Skilled Nursing Facility Nursing Facility Hospice
- Inpatient Psychiatric Psychiatric Residential Treatment End Stage Renal Facility
- Psychiatric Facility Pharmacy Other

Indicate where the drug is being administered:

- Ambulatory surgical Home Inpatient Hospital
- Office Outpatient Hospital Pharmacy

What is the ICD-10 code? _____

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Rituxan Hycela MR HMSACOM C26293-A, C14851-A – 01/2026.

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Exception Criteria Questions:

A. The preferred products for your patient's health plan are Riabni and Truxima

Can the patient's treatment be switched to a preferred product?

Yes, *Skip to Criteria Questions*

No, *Continue to Question B*

B. Does the patient have a documented intolerable adverse event to treatment with both of the preferred products, Riabni and Truxima? **Action Required:** If 'Yes', attach supporting chart note(s)

Yes, *Continue to Question C*

No, *Skip to Criteria Questions*

C. Was the documented intolerable adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the reference product and biosimilar products)? **Action Required:** If 'No', attach supporting chart note(s)

Yes, *Continue to Criteria Questions*

No, *Continue to Criteria Questions*

Criteria Questions:

1. Please list or describe all agents in the oncology regimen. Single agent Multiple agents

2. What is the patient's diagnosis and ICD 10 code? **ACTION REQUIRED:** *Please attach relevant and supportive data of patient's diagnosis.*

3. Is the requested medication/regimen prescribed for an FDA-approved indication, an indication supported by NCCN with a I or IIA recommendation? Yes No

4. Does the patient have a contraindication to the use of the requested medication(s) as listed in the medication(s) prescribing information? Yes No

5. Was the single agent or entire drug regimen previously authorized by HMSA/CVS for this member?

Yes No Unknown *If No or unknown, no further questions.*

6. Is there evidence to support the patient is benefitting from treatment (e.g. positive clinical response, lack of disease progression)? **ACTION REQUIRED:** *Please attach current clinical documentation (e.g., office visit notes and applicable studies) that supports treatment is beneficial.* Yes No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X _____

Prescriber or Authorized Signature

Date (mm/dd/yy)

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