



**Rituxan Hycela® (rituximab and hyaluronidase) Medication
Precertification Request**

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(All fields must be completed and legible for Precertification Review)

Aetna Precertification Notification

Phone: 1-866-752-7021

FAX: 1-888-267-3277

For Medicare Advantage Part B:

Phone: 1-866-503-0857

FAX: 1-844-268-7263

Please indicate: Start of treatment: Start date ____ / ____ / ____
 Continuation of therapy, Date of last treatment ____ / ____ / ____

Precertification Requested By: _____ **Phone:** _____ **Fax:** _____

A. PATIENT INFORMATION

First Name:		Last Name:		DOB:	
Address:			City:		State: ZIP:
Home Phone:		Work Phone:		Cell Phone: Email:	
Patient Current Weight: ____ lbs or ____ kgs		Patient Height: ____ inches or ____ cms		Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____		Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Group #: _____		If yes, provide ID#: _____ Carrier Name: _____	
Insured: _____		Insured: _____	
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____		Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	

C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.	
Address:			City:		State: ZIP:
Phone:		Fax:		St Lic #: NPI #: DEA #: UPIN:	
Provider Email:			Office Contact Name:		Phone:
Specialty (Check one): <input type="checkbox"/> Oncologist <input type="checkbox"/> Other: _____					

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:		Dispensing Provider/Pharmacy: Patient Selected choice	
<input type="checkbox"/> Self-administered	<input type="checkbox"/> Physician's Office	<input type="checkbox"/> Physician's Office	<input type="checkbox"/> Retail Pharmacy
<input type="checkbox"/> Outpatient Infusion Center	Phone: _____	<input type="checkbox"/> Specialty Pharmacy	<input type="checkbox"/> Other _____
Center Name: _____		Name: _____	
<input type="checkbox"/> Home Infusion Center	Phone: _____	Address: _____	
Agency Name: _____		Phone: _____ Fax: _____	
<input type="checkbox"/> Administration code(s) (CPT): _____		TIN: _____ PIN: _____	
Address: _____			

E. PRODUCT INFORMATION

Request is for: Rituxan Hycela (rituximab and hyaluronidase) Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For All Requests (clinical documentation required):

Please indicate the patient's documented diagnosis:

- Castleman's disease (CD)
- Chronic lymphocytic leukemia (CLL)
- Diffuse large B-cell lymphoma (DLBCL)
- Follicular lymphoma (FL)
- Gastric mucosa-associated lymphoid tissue (MALT) lymphoma
- Hairy cell leukemia
- High-grade B-cell lymphoma (including high-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 [double/triple hit lymphoma], high-grade B-cell lymphoma, not otherwise specified)
- Histologic transformation of nodal marginal zone lymphoma to diffuse large B-cell lymphoma
- Mantle cell lymphoma
- Nodal marginal zone lymphoma
- Nongastric MALT lymphoma
- Post-transplant lymphoproliferative disorder (PTLD)
- Primary cutaneous B-cell lymphoma (e.g., cutaneous marginal zone lymphoma or cutaneous follicle center lymphomas)
- Small lymphocytic lymphoma (SLL)
- Splenic marginal zone lymphoma
- Waldenström Macroglobulinemia/ Lymphoplasmacytic Lymphoma

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

For Initiation Requests (clinical documentation required):

Yes No Does the patient have CD20 positive disease that was confirmed by testing or analysis?

Yes No Has the patient received at least one full dose of a rituximab product by **IV infusion** without experiencing severe adverse reactions?

For Continuation Requests (clinical documentation required):

Yes No Is there evidence of unacceptable toxicity on the current regimen?

H. ACKNOWLEDGEMENT

Request Completed By (Signature Required): _____ **Date:** ____ / ____ / ____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.