Premier Health Plan
Pharmacy Services
Commercial Phone: 855-266-0713
Exchange Phone: 866-822-2413
Fax: 855-862-6518

RITUXAN
Prior Authorization Form

□ Standard Request □ Expedited Request	If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. ***For state exchanges only:*** The above disclaimer applies for exigent circumstances. Expedited review may also be requested when you are undergoing a current course of treatment using a non-formulary drug.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested:	Strength:	Directions:	Quantity Dispensed:	Day Supply:
Rituxan	□ 100mg/10ml Solution □ 500mg/50ml Solution			

□ New medication □ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.

Medication Information

Drug Requested:	Strength:	Directions:
Quantity Dispensed:	Day Supply:	□ Generic □ Brand Necessary

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

□ New medication □ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.

Clinical Information

□ Rheumatoid Arthritis	Has the member tried and failed methotrexate for at least 3 months?	□ Yes	□ No
	Is the member on methotrexate currently?	□ Yes	□ No
	If no, is the member taking another disease-modifying anti-rheumatic drug (DMARD)? Medication:_____	□ Yes	□ No
	Has the member tried and failed any Tumor Necrosis Factor (TNF) inhibitors for at least 3 months?	□ Yes	□ No
	Is the member using another TNF-blocking agent or biologic in combination with Rituxan?	□ Yes	□ No
	Does the member have a history of or current case of Progressive Multifocal Leukoencephalopathy?	□ Yes	□ No

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Member Name:	DOB:	Health Plan ID:
Please be sure to complete and include this page with the 1st page of this form.		

☐ Rheumatoid Arthritis	Disease Severity: ☐ Mild ☐ Moderate ☐ Severe	PPD (tuberculin) test: ☐ Positive ☐ Negative Date:_____		Does the member have evidence of severe active infection? ☐ Yes ☐ No		
	Please indicate past medication(s) tried for at *least 3 months* and failed:					
	Medication	**Start Date**	**End Date**	**Strength**	**Frequency**	**Reason for Discontinuing**

☐ Wegener's Granulomatosis ☐ Microscopic Polyangitis	Will the member be taking glucocorticoids in combination with Rituxan?	☐ Yes ☐ No
	Does the member have evidence of severe active infection?	☐ Yes ☐ No
	Is Rituxan being used as induction therapy?	☐ Yes ☐ No

☐ Desensitization for Renal or Pancreatic Transplant in combination with IVIG	Type of transplant: ☐ Kidney ☐ Pancreas	
	Will Rituxan be used in combination with IVIG?	☐ Yes ☐ No
	Does the member have a history of or current case of Progressive Multifocal Leukoencephalopathy (PML)?	☐ Yes ☐ No
	Donor Type:	
	☐ Living	Was donor a positive crossmatch? ☐ Yes ☐ No Is donor-specific antibody positive using Luminex Assay? ☐ Yes ☐ No
	☐ Deceased	Please provide panel reactive antibody (PRA) level (%): _____ Has the member had a previous kidney or pancreas transplant? ☐ Yes ☐ No

☐ Cancer	Does the member have Non-Hodgkin's Lymphoma (NHL)? ☐ Yes ☐ No If yes, please indicate specific type: _____ Does the member have Chronic Lymphocytic Leukemia (CLL)? ☐ Yes ☐ No If yes, please indicate specific type: _____ Does the member have another type of cancer? ☐ Yes ☐ No If yes, please indicate specific type: _____ *Please provide clinical rationale and literature to support use of Rituxan for this diagnosis.*
☐ Other	Diagnosis:_____ Please provide clinical rationale and literature to support use of Rituxan for this diagnosis.

Please provide any additional information which should be considered in the space below:

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