

RITUXAN Prior Authorization Form

<input type="checkbox"/> Standard Request (72 hours) <input type="checkbox"/> Expedited Request (24 hours)	If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For expedited requests you will receive a decision within 24 hours. You cannot request an expedited coverage determination if you are requesting reimbursement for a drug you already received.
---	---

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: Rituxan	Strength: <input type="checkbox"/> 100mg/10ml Solution <input type="checkbox"/> 500mg/50ml Solution	Directions:	Quantity Dispensed:	Day Supply:
<input type="checkbox"/> New medication <input type="checkbox"/> Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.		

Billing Information

<input type="checkbox"/> Billed by PHARMACY dispensed to the member or provider for administration.	<input type="checkbox"/> Billed under MEDICAL benefit by provider. J CODE: _____ ICD-10 Code: _____	Place of Administration: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital/Clinic <input type="checkbox"/> Patient Home
--	--	--

Clinical Information

<input type="checkbox"/> Rheumatoid Arthritis	Is the member on methotrexate currently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Has the member tried and failed therapy with Humira (adalimumab)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Has the member tried and failed therapy with Enbrel (etanercept)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Is the member using another TNF-blocking agent or biologic in combination with Rituxan?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Does the member have a history of or current case of Progressive Multifocal Leukoencephalopathy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Disease Severity: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe		Does the member have evidence of severe active infection? <input type="checkbox"/> Yes <input type="checkbox"/> No	

	Please indicate past medication(s) tried for at <i>least 3 months</i> and failed:					
	Medication	Start Date	End Date	Strength	Frequency	Reason for Discontinuing
<input type="checkbox"/> Wegener's Granulomatosis <input type="checkbox"/> Microscopic Polyangitis	Will the member be taking glucocorticoids in combination with Rituxan? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the member have evidence of severe active infection? <input type="checkbox"/> Yes <input type="checkbox"/> No Is Rituxan being used as induction therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<input type="checkbox"/> Cancer	Does the member have Non-Hodgkin's Lymphoma (NHL)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate specific type: _____ Does the member have Chronic Lymphocytic Leukemia (CLL)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate specific type: _____ Does the member have another type of cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate specific type: _____ <i>Please provide clinical rationale and literature to support use of Rituxan for this diagnosis.</i>					
<input type="checkbox"/> 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:						