Please complete ALL information below and fax your request to 1-888-671-5285

Rituxan® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			**Provider Information** (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Chronic lymphocytic leukemia (CLL)
❑ Granulomatosis with polyangitis (GPA) (Wegener's granulomatosis) and microscopic polyangitis (MPA)
❑ Immune or idiopathic thrombocytopenic purpura (ITP)
❑ Moderately to severely active rheumatoid arthritis
❑ Non-Hodgkin's lymphoma (NHL)
❑ Pemphigus vulgaris
❑ Other diagnosis: ______________________________ ICD-10 Code(s): ______________________________

Prescriber's Specialty:

Select if Rituxan is prescribed by or in consultation with the following, as appropriate for the patient's diagnosis:

❑ Dermatologist
❑ Hematologist/oncologist
❑ Nephrologist
❑ Pulmonologist
❑ Rheumatologist

For chronic lymphocytic leukemia (CLL), answer the following:

Will the patient use Rituxan in combination with fludarabine and cyclophosphamide? ❑ **Yes** ❑ **No**

For granulomatosis with polyangitis (GPA) (Wegener's granulomatosis) and microscopic polyangitis (MPA), answer the following:

Select the diagnosis that applies to the patient:

❑ Granulomatosis with polyangitis (Wegener's granulomatosis)
❑ Microscopic polyangitis

Is the patient concurrently on glucocorticoids (e.g., prednisone)? ❑ **Yes** ❑ **No**

If "no," does the patient have history of **contraindication or intolerance** to glucocorticoids (e.g., prednisone)? ❑ **Yes** ❑ **No**

For immune or idiopathic thrombocytopenic purpura, answer the following:

Select if the patient has had a trial and failure, contraindication, or intolerance to the following:

❑ Corticosteroids
❑ Immunoglobulins
❑ Splenectomy

Does the patient have a documented platelet count of less than 50×10^{9}/L? ❑ **Yes** ❑ **No**

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of FutureScripts. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: Rituxan_FSP_2019Jun1-W

Rituxan® Prior Authorization Request Form (Page 2 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

For moderately to severely active rheumatoid arthritis, answer the following:

Is the patient concurrently on methotrexate? ❑ **Yes** ❑ **No**

If "no" to the above question, does the patient have history of **contraindication or intolerance** to methotrexate? ❑ **Yes** ❑ **No**

Select if the patient has had a trial and failure, contraindication, or intolerance to the following, or attestation demonstrating a trial may be inappropriate:

- ❑ Cimzia (certolizumab)
- ❑ Humira (adalimumab)
- ❑ Simponi (golimumab) or Simponi Aria (golimumab IV)

Select if the patient has had a trial and failure, contraindication, or intolerance to the following:

- ❑ Actemra (tocilizumab)
- ❑ Xeljanz (tofacitinib) or Xeljanz XR (tofacitinib ER)

Is this request for continuation of prior Rituxan therapy? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation the patient has had a positive clinical response to Rituxan therapy? ❑ **Yes** ❑ **No**

Have at least 16 weeks elapsed since the last course of therapy? ❑ **Yes** ❑ **No**

For non-Hodgkin's lymphoma (NHL), answer the following:

Select the diagnosis that applies to the patient:

- ❑ Diffuse large B-cell, CD20-positive, NHL
  - Will Rituxan be used as first-line treatment in combination with CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) or other anthracycline-based chemotherapy regimens? ❑ **Yes** ❑ **No**
- ❑ Follicular, CD20-positive, B-cell NHL
  - Will Rituxan be used as a first-line treatment in combination with chemotherapy? ❑ **Yes** ❑ **No**
  - Will Rituxan be used as monotherapy for maintenance therapy? ❑ **Yes** ❑ **No**
  - Has the patient achieved a complete or partial response to Rituxan in combination with chemotherapy? ❑ **Yes** ❑ **No**
- ❑ Low-grade, CD20-positive, B-cell NHL
  - Does the patient have stable disease following first-line treatment with CVP (cyclophosphamide, vincristine, prednisolone/prednisone) chemotherapy? ❑ **Yes** ❑ **No**
  - Has the patient achieved a partial or complete response following first-line treatment with CVP chemotherapy? ❑ **Yes** ❑ **No**
- ❑ Relapsed or refractory, low-grade or follicular CD20-positive, B-cell NHL

For pemphigus vulgaris, answer the following:

Does the patient have moderate to severe disease? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation the patient has had a positive clinical response to Rituxan therapy? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

____

____

Please note: This request may be denied unless all required information is received.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of FutureScripts. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**