MedStar Medicare Choice
Pharmacy Services
Phone: 855-266-0712
Fax: 855-862-6517

RITUXAN
Prior Authorization Form

□ Standard Request (72 hours) □ 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:	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.

Billing Information

□ Billed by **PHARMACY** dispensed to the member *or* provider for administration.	□ Billed under **MEDICAL** benefit by provider. J CODE:_____ ICD-10 Code:_____	Place of Administration: □ Physician's Office □ Hospital/Clinic □ Patient Home

Clinical Information

□ Rheumatoid Arthritis

Is the member on methotrexate currently?	□ Yes	□ No
Has the member tried and failed therapy with Humira (adalimumab)?	□ Yes	□ No
Has the member tried and failed therapy with Enbrel (etanercept)?	□ 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

Disease Severity:
□ Mild
□ Moderate
□ Severe

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					
☐ 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: