

Pharmacy Prior Authorization Form

Last reviewed: Sept. 11

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Rituxan (rituximab)

Urgent

Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:

Rituxan 10 mg

Requested Dose: _____ mg/m² Dosing Frequency: q _____ wks Start Date: _____

Place of administration:

Self-administered

Provider's Office

Outpatient Infusion Center

Home Infusion

Name of center: _____

Name of agency: _____

Billing options:

Physician buy and bill

Preferred Specialty Vendor

Other: _____

Priority Health Precertification Requirements

Authorization of Rituxan requires:

- One of the following diagnoses:
 1. Non-Hodgkin's Lymphoma
 2. Rheumatoid Arthritis (all of the following are required)
 - Therapeutic trial and clinical failure with one or more DMARD
 - Patient must be treated with methotrexate concurrently
 - Therapeutic trial and clinical failure with a self-injectable TNF antagonist (e.g. Enbrel, Humira)
 3. Other CD20-expressing neoplasm (e.g. chronic lymphocytic leukemia, Waldenström macroglobulinemia, hairy cell leukemia, mantle cell lymphoma).
 4. Thrombocytopenic purpura (one of the following is required)
 - Patient did not respond to plasma exchange
 - Patient developed worsening disease in spite of continuing plasma exchange plus glucocorticoids
 - Patient has relapsing disease

5. Other Non-FDA approved indication with supportive evidence of efficacy. Fax peer-reviewed clinical literature supporting efficacy for this diagnosis.

- Indications without reliable supporting evidence for efficacy will not be authorized. Examples include: systemic lupus erythematosus (SLE) and lupus nephritis.

Please complete the following:

Diagnosis:

- Non-Hodgkin's Lymphoma – ICD code: _____
- Rheumatoid Arthritis – ICD code: _____
- Other CD20-expressing neoplasm – ICD code: _____
- Thrombocytopenic purpura – ICD code: _____
- Other: _____ – ICD code: _____

Please provide rationale for use: _____

Body Surface Area (BSA): _____ m² Height: _____ inches Weight: _____ lbs

Note: BSA (m²) = ([height(in) x weight(lbs)] / 3131)^½

New request or continuation of therapy:

- New Continuation

For Continuation of therapy, has the patient responded to therapy?

- Yes
- No – Rationale for use: _____

For Rheumatoid Arthritis (RA), will Rituxan be used in combination with methotrexate?

- Yes
- No – Rationale for use: _____

For Rheumatoid Arthritis, has the patient had a therapeutic trial and clinical failure with one or more DMARDs (see table 2)? If yes, list the drug and trial date below.

- Yes
 - Drug: _____ Trial dates: _____
 - Drug: _____ Trial dates: _____

- No – Rationale for use _____

For Rheumatoid Arthritis, has the patient had a therapeutic trial and clinical failure with a self-injectable TNF antagonist (e.g. Enbrel, Humira)? If yes, list the drug and trial date.

- Yes
 - Drug: _____ Trial dates: _____

- No – Rationale for use _____

For thrombocytopenic purpura, has the patient had one of the following (check which applies)?

- Patient did not respond to plasma exchange
- Patient developed worsening disease in spite of continuing plasma exchange plus glucocorticoids
- Patient has relapsing disease

Approval, when granted, will be at the dose and duration outlined below in table 1.

TABLE 1. Dose and Duration of Authorization

Indication Initia	I Authorization	Continuation Authorization
Adult rheumatoid arthritis	<ul style="list-style-type: none"> Approved for 3 months Approved dose is 1,000mg IV on days 1 and 15. May be repeated 6 months later 	<ul style="list-style-type: none"> Approved for an additional 12 months if the patient has responded, as determined by the prescribing physician Approved dose is 1,000mg IV every two weeks
Non-Hodgkin's Lymphoma	<ul style="list-style-type: none"> Approve for 12 months Approved dose is 375mg/m² IV once weekly 	
Other CD20-expressing neoplasm	<ul style="list-style-type: none"> Approved for 8 weeks Approved dose is 375mg/m² IV once weekly 	

TABLE 2. Disease Modifying Antirheumatic Drugs (DMARDs)

Generic Name	Trade Name
azathioprine (oral)	generics, Imuran [®]
cyclosporine (oral)	generics, Neoral [®] , Sandimmune [®]
d-penicillamine (oral)	Cuprimine [®] , Depen [®]
gold compounds	
gold sodium thiomalate (injection)	Aurolate [®]
auranofin (oral)	Ridaura [®]
aurothioglucose (injection)	Solganal [®]
hydroxychloroquine (oral)	generics, Plaquenil [®]
leflunomide (oral)	generics, Arava [®]
methotrexate [MTX] (oral, injection)	generics, Rheumatrex [®]
sulfasalazine (oral)	generics, Azulfidine En-tabs [®] , Azulfidine

*** All fields must be complete and legible for Prior Authorization Review***

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX