MedStar Health

MedStar Health
Pharmacy Services
Phone: 866-822-0750
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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.

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

Question		
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

Disease Severity:
□ Mild
□ Moderate
□ Severe

PPD (tuberculin) test:
□ Positive
□ Negative
Date:_______________

Does the member have evidence of severe active infection? □ Yes □ No

www.medstarprovidernetwork.org/ms_pharm_prior_authorization_forms.html Revised: 10/2015

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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	**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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