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RITUXIMAB (RITUXAN®) MP-2.110

Preauthorization Request

(Preauthorization is not a guarantee of payment)

SECTION I – General Information

Initial start date of therapy: / / Anticipated date of next infusion: / /	Fax completed form to: **1-866-805-4150 toll free**

SECTION II – Member Information

Member Name:	Member ID:	Member DOB: / /

Plan Type: ☐ Traditional ☐ Comprehensive ☐ PPO ☐ POS ☐ KHPC ☐ Special Care ☐ Sr. Blue HMO ☐ Sr. Blue PPO

SECTION III – Provider Information Required

Requesting Provider Name: **Address**:	**Requesting Provider:** **CBC #**_____ **NPI #** _____
Telephone #:	Fax #:
Office Contact Name:	Office Contact Telephone #:

Place of Service: ☐ MD Office ☐ Name/Address of the Hospital/Clinic/Home Health

SECTION IV – Preauthorization Requirements and Clinical Criteria

A. Complete this Section for diagnosis of Rheumatoid Arthritis

Diagnosis ICD Code: _____ HCPC Code J9310

Prescribed in consultation with a rheumatologist? ☐ Yes ☐ No

☐ ***Initial Authorization*** *To be completed for initial treatment*.

Initial course is 2 infusions in combination with methotrexate separated by 2 weeks.

Is there a documented therapeutic trial of one or more tissue necrosis factor (TNF) blockers (e.g. entanercept [Enbrel®], adalimumab [Humira®], golimumab [Simponi®], certolizumab [Cimzia®], or infliximab [Remicade]).

☐ Yes ☐ No

Note: If yes, please list any previous medications that were tried and failed. Include reason for discontinuation (intolerance, hypersensitivity etc). Please attach clinic notes.

1. Name of TNF Trial Dates: / / through / /

Reason for discontinuation

2. Name of TNF: Trial Dates: / / through / /

Reason for discontinuation

☐ ***Re-Authorization (Retreatment) To be completed for continuation of therapy.***

(Administered in combination with methotrexate every 24 weeks. Frequency is based on clinical evaluation but not sooner than every 16 weeks.)

Has the patient demonstrated improvement as measured by a standardized disease activity tool (e.g., Rheumatoid Arthritis Disease Activity Index [RADAI]? Yes ☐ No ☐

B. Complete this Section for Diagnosis of B-cell non-Hodgkin Lymphoma (NHL)

Diagnosis ICD Code: _____ HCPC Code J9310

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For follicular lymphoma choose all that apply	☐ Used as first-line therapy (as combination therapy or as monotherapy)	☐ Used as second or subsequent therapy (as combination therapy or as monotherapy)	☐ Used as single-agent maintenance therapy (first- or second-line) in patients who achieve a complete or partial response to Rituxan in combination with chemotherapy	☐ Other Document and submit clinical
For NHL **other than** follicular lymphoma choose all that apply	☐ Used with CHOP or other anthracycline-based chemotherapy as first-line treatment for patients with diffuse large B-cell lymphoma (DLBCL)	☐ Treatment for recurrent, aggressive CD20-positive NHL	☐ Used for previously untreated or relapsed/refractory mantle cell lymphoma	☐ Used as combination therapy in previously untreated and previously treated B-cell chronic lymphocytic leukemia (B-CLL).

C. Complete this Section for Non-oncologic indications

Diagnosis ICD Code: _____ HCPC Code J9310

Choose all that apply	☐ Treatment of ***symptomatic*** Waldenstrom's Macroglobulinemia (include documentation of symptoms)	☐ Treatment of Wegener's Granulomatosis	☐ Treatment of microscopic polyangiitis (MPA) in adult patients in combination with glucocorticoids
	☐ Treatment of refractory immune (idiopathic) thrombocytopenia purpura (ITP)	☐ Treatment of ***acute*** renal transplant rejection	☐ Other: Document and submit clinical

Dosing Information

Dose: Frequency:

SECTION V – Required Physician Signature

Physician's Signature	Date: / /