

Fax completed form to: 1-866-868-0858
Questions, please call: 1-866-316-6049

Avera Advantage™

Important Information About Prescription Drug Coverage

To: _____ From: _____

Fax: _____ Pages: _____

Re: Rituxan® (Rituximab): Prior Authorization Request Form: Please respond.

- Please complete the attached Rituxan® (Rituximab) Prior Authorization Request Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

Please note: By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

Information about this drug

Rituxan® (Rituximab)
Rituximab should be considered an absolute last line agent in the treatment of rheumatoid arthritis. Patients should fail multiple standard therapies (e.g., methotrexate, Humira®) before progressing to rituximab. The FDA recently released a warning against the use of rituximab in patients with rheumatoid arthritis and lupus due to cases of progressive multifocal leukoencephalopathy, which resulted in fatalities. If rituximab is approved for rheumatoid arthritis, consider employing only 500 mg. In one trial, a 24 week ACR response was observed in 55% of patients who received the 500 mg dose vs. 54% who received the 1,000 mg dose (Emery P. Arthritis & Rheum. 2006;54(4):1390-1400)

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.

Prior Authorization Request Form

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Patient Information

Name _____
Member ID _____
Medicare ID _____
Date of birth _____ Sex: M / F
Address _____
City _____
State _____ ZIP _____
Phone _____
Nursing home resident? YES / NO
Home care patient? YES / NO

Prescriber and Pharmacy Information

Name _____
Specialty _____
DEA _____
NPI _____
Address _____
City _____
State _____ ZIP _____
Phone _____ Fax _____
Pharmacy name _____
NCPDP _____
NPI _____
Phone _____ Fax _____

All items below this line are for Physician Use Only

Information for Requested Drug

Strength: _____ Dosage form: _____ Qty per 30 days: _____ Drug is (circle one): Newly prescribed/Refill
Directions: _____ Diagnosis: _____ ICD-9 Code: _____

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

Rituxan® (Rituximab) Criteria

- Please indicate Rituxan®'s dispensing location:
 pharmacy
 physician's supply incident to a physician's service
 other: _____
- Please indicate the patient's diagnosis. Select or specify the correct ICD-9 code. This question must be completed.
 B-cell, CD20-positive, Non-Hodgkin's lymphoma(ICD-9: 200,202)
 Rheumatoid arthritis (Moderate to Severe), in combination with methotrexate (ICD-9: 714.0)
 Other (diagnosis and ICD-9): _____
- Please specify the diagnosis code(s) supporting the necessity for the requested agent. This question must be completed.
 ICD-9: _____
- Is the prescribing physician a hematologist/oncologist or rheumatologist or has one been consulted?
 Yes No
- Will Rituxan® be administered in a facility where the patient can be closely monitored for an appropriate period based on health status?
 Yes No
- If the diagnosis treated is RA, has the patient failed to receive a clinically appropriate therapeutic response OR demonstrated intolerance (e.g., allergy, hypersensitivity, adverse effects(s), development of a contraindication) from two DMARDs (one of which is MTX), one TNF-antagonist (e.g., Humira®), and Orenicia® over a period of 90 or more days for each drug?
 Yes No

Medical justification: (Attach additional page if necessary): _____

Prescriber's signature: _____ Date: _____