

# Drug Coverage Review Request

**Rituxan<sup>®</sup>**



## SUPPLY ALL PRESCRIBER AND PATIENT INFORMATION

### PATIENT

MD First Name \_\_\_\_\_  
MD Last Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Zip Code \_\_\_\_\_  
Phone \_\_\_\_\_  
Fax \_\_\_\_\_  
DEA number (optional) \_\_\_\_\_

### PATIENT

Cardholder ID # \_\_\_\_\_  
Patient Last Name \_\_\_\_\_  
Patient First Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Zip Code \_\_\_\_\_  
Phone \_\_\_\_\_

Your patient's benefit plan requires that we review certain requests for coverage with the prescribing physician. This includes requests for benefit coverage beyond plan specifications. Please complete the following questions and then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the benefit plan's rules.

## SECTION A Please answer the following questions

- Yes  No Will the patient be receiving MORE THAN ONE biologic rheumatoid arthritis agent (*Enbrel, Kineret, Humira, Remicade, Orencia or Rituxan*) AT THE SAME TIME?
- For which indication will this drug be used?
  - Non-Hodgkin's lymphoma
  - Moderate to severe rheumatoid arthritis in combination with methotrexate\*  $\wedge$  answer questions 3-6
  - Other

**\*Questions 3-6 apply only if diagnosis is moderate to severe rheumatoid arthritis in combination with methotrexate**

- Yes  No Has the patient already received a dose of this drug?
- Yes  No IF **Yes** to **previous** question, have at least 6 months passed since the last infusion of this drug?
- Yes  No Has the patient had INADEQUATE RESPONSE to previous drug therapy with at least one tumor necrosis factor (TNF) inhibitor (that is, *Remicade, Enbrel, or Humira*)?
- Yes  No If **No** to **previous** questions, has the patient EXPERIENCED INTOLERANCE to ALL TNF inhibiting drugs (that is, *Remicade, Enbrel, and Humira*)?

## SECTION B Physician Signature

\_\_\_\_\_  
PHYSICIAN SIGNATURE

\_\_\_\_\_  
DATE

**FAX COMPLETED FORM TO: 1 800 837-0959**

PLEASE DO NOT FAX WITH A COVER SHEET



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