

RITUXAN

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services. Otherwise please return completed form to:
UPMC HEALTH PLAN PHARMACY SERVICES PHONE 800-979-UPMC (8762) FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY.

Incomplete responses may delay this request.

Office Contact:		Provider Specialty: <input type="checkbox"/> Rheumatologist <input type="checkbox"/> Transplant <input type="checkbox"/> Other (Please List): _____			
Provider First Name:		Provider Last Name:			
Provider Phone:		Provider Fax:		Provider NPI #:	
Patient Name:	Patient UPMC Health Plan ID Number:	Patient DOB:	Patient Age:	Patient Height:	Patient Weight:
Drug Requested: <input type="checkbox"/> Brand <input type="checkbox"/> Generic	Strength:	Frequency:	Qty Dispensed:		
Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.					
<input type="checkbox"/> New medication	If ongoing, provide date started:	If medication is ongoing, Did the member show improvement while on therapy?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Diagnosis:		Date of diagnosis:			
Please indicate place of administration?		<input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital/Facility		Please indicate how medication will be billed: <input type="checkbox"/> Billed directly by the provider via JCODE Provide JCODE: _____ <input type="checkbox"/> Billed by a pharmacy and delivered to the provider <input type="checkbox"/> Billed by a pharmacy and delivered to the patient	
Please provide facility/provider name and address:					

Please indicate the diagnosis on the left and complete the corresponding questions.

<input type="checkbox"/> Rheumatoid Arthritis:	Please indicate disease severity:	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
	Is the member currently on Methotrexate?	<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, indicate start date: _____
	Has the member been on Methotrexate for at least 3 months with an inadequate response?	<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please indicate dates of trial: _____ If NO, please specify reason why Methotrexate cannot be used:
	Has the member been on a TNF- blocking agent (i.e. Enbrel, Humira) for at least 3 months with an inadequate response?	<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, Please specify medication and dates of trial: _____ If NO, Please specify reason why a TNF blocking agent cannot be used:
	Is the member using another TNF-blocking agent or other biologic agent in combination with Rituxan?	<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please specify medication:
	Does member have or has had a history of Progressive Multifocal Leukoencephalopathy (PML)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Does member have evidence of severe active infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please be sure to complete and include the 2nd page of this form

**Rituxan
Page 2**

Patient Name	Patient UPMC Health Plan ID Number:	Patient DOB:
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Please be sure to complete and include this page with the 1st page of this form

<input type="checkbox"/> Desensitization in kidney and/or pancreatic transplant in combo with IVIG	Type of Organ Transplant <input type="checkbox"/> Kidney <input type="checkbox"/> Pancreas	
	Will Rituxan be given in combination with IVIG?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Does member have or has had a history of Progressive Multifocal Leukoencephalopathy(PML)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Please indicate donor type below	
	<input type="checkbox"/> Deceased: Please complete the following: Please provide panel reactive antibody (PRA) level(%): _____ Did the member have a previous kidney and/or pancreas transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Living: Please complete the following: Is crossmatch positive? <input type="checkbox"/> Yes <input type="checkbox"/> No Is donor-specific antibody positive using Luminex assay? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Wegener's Granulomatosis	Will the member be taking glucocorticoids in combination with Rituxan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Does the member have evidence of severe active infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Microscopic Polyangitis	Is Rituxan being used as induction therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please provide any additional information which should be considered in the space below:
