UPMC Health Plan

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.

Please complete all sections of this form. Incomplete responses may delay this request.

Office Contact:	**Provider Specialty:** ☐ Rheumatologist ☐ Transplant ☐ 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:**

Drug Requested:	**Strength:**	**Frequency:**	**Qty Dispensed:**	**Patient Age:**

Generic equivalent drugs will be substituted for brand-name drugs unless you specifically indicate otherwise.

☐ **New medication** ☐ **Ongoing medication**	**If ongoing, provide date started:**	**If medication is ongoing, did the member show improvement while on therapy?**	☐ **Yes** ☐ **No**

Diagnosis:	**Date of diagnosis:**

Please indicate place of administration/ infusion:	☐Physician Office ☐Hospital/Facility ☐Patient Home	**Please indicate how medication will be billed:** ☐ Billed directly by the provider via JCODE Please provide JCODE: ____________________ ☐ Billed by a pharmacy and delivered to the provider ☐ 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.

☐ Rheumatoid Arthritis

Please indicate disease severity: ☐ Mild ☐ Moderate ☐ Severe

Question	Response
Has the member tried and failed methotrexate for at least 3 months? If yes, please provide dates of trial: ____	☐ Yes ☐ No
Is the member on methotrexate currently? If yes, please indicate start date: ____ If no, please indicate why methotrexate cannot be used: ________________________ ____	☐ Yes ☐ No
If no, is the member taking another disease-modifying anti-rheumatic drug (DMARD)? Please provide name of medication and start date of treatment: ______________ ____	☐ Yes ☐ No
Has the member tried and failed any Tumor Necrosis Factor (TNF) inhibitors for at least 3 months? If yes, please provide the following:	☐ Yes ☐ No

Medication name and dose frequency	Start date	End date	Reason for discontinuation/failure

If no, please indicate why TNF inhibitor(s) cannot be used: ______________________________
____

Question	Response
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
Does the member have evidence of severe active infection?	☐ Yes ☐ No

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

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Patient Name	**Patient UPMC Health Plan ID Number:**	**Patient DOB:**

Please be sure to complete and include this page with the 1st page of this form

☐ 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

Please indicate donor type:

☐ Deceased	☐ Living
Please provide panel reactive antibody (PRA) level (%): ______________________ Has the member had a previous kidney or pancreas transplant? ☐ Yes ☐ No	Was donor a positive crossmatch? ☐ Yes ☐ No Is donor-specific antibody positive using Luminex Assay? ☐ Yes ☐ No

☐ Cancer	Does the member have Non-Hodgkin's Lymphoma (NHL)? If yes, please indicate specific type: ______________________	☐ Yes ☐ No
	Does the member have Chronic Lymphocytic Leukemia (CLL)? If yes, please indicate specific type: ______________________	☐ Yes ☐ No
	Does the member have another type of cancer? If yes, please indicate specific type: ______________________ Please provide clinical rationale and literature to support use of Rituxan for this diagnosis.	☐ Yes ☐ No

☐ Other	Diagnosis:
	Please provide clinical rationale and literature to support use of Rituxan for this diagnosis.

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