



Send completed form to:
 Peach State Health Plan Pharmacy Department
 Fax: 1-866-374-1579

Rituxan

Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copy or medication delivery; please contact Peach State Health Plan at 1-800-514-0083 option # 2.

Patient Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Physician Office Address: _____

1. What drug is being prescribed? Rituxan, Dose: _____ Frequency: _____ Other _____
2. What is the diagnosis?
 Rheumatoid arthritis (RA) Other _____
 Immune (idiopathic) thrombocytopenic purpura (ITP)
3. How old is the patient? _____ years

Complete the Section below designated for the patient's diagnosis

SECTION A: Immune (idiopathic) thrombocytopenic purpura (ITP)

4. Does the patient have persistent severe thrombocytopenia defined as platelet count less than 30,000/uL? **If Yes, Skip to # 6* Yes No
5. Does the patient have documentation of bleeding symptoms or potential risk of clinically significant bleeding? **If Yes, Attach Documentation* Yes No
6. Has the patient had an inadequate response to first line treatments including steroids and/or intravenous immunoglobulins (IVIG)? Yes No

SECTION B: Rheumatoid arthritis (RA)

7. What is the medical specialty of the prescribing physician?
 Rheumatologist
 Specialist in treating rheumatoid arthritis
 Other _____
8. Does the patient have history of Hepatitis B infection? Yes No **If No, Skip to # 10*
9. Has the patient been treated for Hepatitis B infection? Yes No
10. Does the patient have signs or symptoms of active infection, either chronic or localized?
 Yes No
11. Is Rituxan or will Rituxan be used in combination with methotrexate (MTX)? Yes No

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Patient Name: _____ Patients Date of Birth: _____
Patients ID : _____

12. Prior to therapy, did the patient have 6 or more inflamed joints? Yes No
13. Prior to therapy, did the patient have at least one of the following characteristics? Yes No
- Elevation of erythrocyte sedimentation rate (ESR) and/or serum c-reactive protein (CRP) concentration
 - Positive rheumatoid factor and/or anti-cyclic citrullinated peptide (CCP)
 - Radiography showing evidence of rheumatoid arthritis, including osteopenia and/or joint space narrowing and/or bony erosions and/or loss of cartilage
14. Has the patient had a trial of either methotrexate (MTX) or leflunomide (Arava) for at least 3 consecutive months? Yes No
15. Has the patient had an inadequate response to either MTX or leflunomide (Arava)? Yes No
16. Is the patient intolerant or contraindicated to both MTX and leflunomide (Arava)? Yes No
17. Has the patient had a trial of another non-biologic disease modifying anti-rheumatic drug (DMARD) for at least 3 consecutive months (e.g., hydroxychloroquine, cyclosporine, sulfasalazine, gold, and azathioprine)? Yes No
18. Has the patient had an inadequate response to such therapy? Yes No
19. Was the patient adherent to prescribed therapy? Yes No
20. Is the patient intolerant or contraindicated to such therapy? Yes No
21. Has the patient had a trial of **at least 1** tumor necrosis factor (TNF) inhibitor for at least 3 consecutive months? (i.e. **Cimzia[®]**, **Enbrel[®]**, **Humira[®]**, **Remicade[®]**, or **Simponi[®]**) Yes No
22. Has the patient had an inadequate response to prescribed TNF inhibitor? Yes No
23. Was the patient adherent to prescribed TNF inhibitor therapy? Yes No
24. Is the patient intolerant or contraindicated to TNF inhibitor? Yes No
25. Document last trial of TNF inhibitor unless contraindicated:
TNF: _____ Length of Therapy: _____
26. Is the patient currently receiving Rituxan therapy? Yes No **If No, no further questions*
- Only answer below if patient is currently on Rituxan therapy for RA:**
27. Has the patient achieved American College of Rheumatology (ACR) 20 response following Rituxan initial therapy? Yes No
28. Has it been at least 6 months since last treatment with Rituxan? Yes No
29. How many months has it been since last treatment with Rituxan? _____ months

****NOTE: We can NOT make a decision without documentation - Thank You****

Information given on this form is accurate as of this date:

X _____
Prescriber or Authorized Signature Date (mm/dd/yy)

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