OPTUMRx®

OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Rituxan® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Chronic lymphocytic leukemia (CLL)
- ❑ Immune or idiopathic thrombocytopenic purpura (ITP)
- ❑ Microscopic polyangiitis (MPA)
- ❑ Moderately to severely active rheumatoid arthritis (RA)
- ❑ Non-Hodgkin's lymphoma (NHL)
- ❑ Wegener's granulomatosis
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is this request for continuation of prior Rituxan therapy? ❑ **Yes** ❑ **No**

Has the patient used Rituxan within the past 120 days? ❑ **Yes** ❑ **No**

Select if Rituxan is prescribed by or in consultation with one of the following specialists, as appropriate for the patient's diagnosis:

- ❑ Hematologist/oncologist
- ❑ Nephrologist
- ❑ Pulmonologist
- ❑ Rheumatologist

For immune or idiopathic thrombocytopenic purpura (ITP), also answer the following:

Has the patient had trial and failure, contraindication, or intolerance to corticosteroids, immunoglobulins, or splenectomy? ❑ **Yes** ❑ **No**

Does the patient have a documented platelet count of less than 50 x 10^9/L? ❑ **Yes** ❑ **No**

For moderately to severely active rheumatoid arthritis, also answer the following:

Is the patient concurrently on methotrexate? ❑ **Yes** ❑ **No**

If "no" to the above question, does the patient have history of **contraindication** or **intolerance** to methotrexate? ❑ **Yes** ❑ **No**

Has the patient had trial and failure, contraindication, or intolerance to one TNF antagonist [e.g., Humira (adalimumab), Enbrel (etanercept), Remicade (Infliximab)]? ❑ **Yes** ❑ **No**

Will the patient be receiving Rituxan in combination with a biologic DMARD [e.g., Enbrel (etanercept), Orencia (abatacept), Kineret (anakinra)]? ❑ **Yes** ❑ **No**

For Wegener's granulomatosis or microscopic polyangiitis, also answer the following:

Is the patient concurrently on glucocorticoids (e.g., prednisone)? ❑ **Yes** ❑ **No**

If "no" to the above question, does the patient have history of **contraindication** or **intolerance** to glucocorticoids (e.g., prednisone)? ❑ **Yes** ❑ **No**

Rituxan® Prior Authorization Request Form (Page 2 of 2)

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For non-Hodgkin's lymphoma (NHL), also answer the following:

Select if the patient has one of the following forms of non-Hodgkin's lymphoma (NHL):

- ❑ Diffuse large B-cell, CD20-positive, NHL

  Will Rituxan be used as first-line treatment in combination with CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) or other anthracycline-based chemotherapy regimens? ❑ **Yes** ❑ **No**
- ❑ Follicular, CD20-positive, B-cell NHL

  Will Rituxan be used as first-line treatment in combination with chemotherapy? ❑ **Yes** ❑ **No**

  Will Rituxan be used as a single-agent maintenance therapy in a patient who has achieved a complete or partial response to Rituxan in combination with chemotherapy? ❑ **Yes** ❑ **No**
- ❑ Low-grade, CD20-positive, B-cell NHL

  Does the patient have stable disease following first-line treatment with CVP (cyclophosphamide, vincristine, prednisolone/prednisone) chemotherapy? ❑ **Yes** ❑ **No**

  Has the patient achieved a partial or complete response following first-line treatment with CVP (cyclophosphamide, vincristine, prednisolone/prednisone) chemotherapy? ❑ **Yes** ❑ **No**
- ❑ Relapse or refractory, low grade or follicular CD20-positive, B-cell NHL

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.