



Rituxan (Rituximab)

Prior Authorization Form Curascript Fax (888) 773-7386

Form with fields: Last Name, First Name, Prescriber's Name, Specialty, Home Phone, Work Phone, Office Phone, Office Fax, Home Address, City, State, ZIP, Address, City, State, ZIP, SCAN ID number, Date of Birth, Est. Start Date, Office Contact, For Specialty Medications Only: Shipping Address (if different from home address), Physician, Home, Special Instructions (i.e. Non-English Speaking Patient, etc.):

Medication: Diagnosis: Sig: Qty: Refills: ICD 9 Code:

Secondary/ Supplemental Insurance Company Phone Name of Insured ID Number Group Number

- 1. Is the diagnosis or indication for the treatment of patients with Non-Hodgkin's Lymphoma? If no continue to #4
2. Does the patient express CD20 positive B-cells confirmed by histologic testing?
3. Is the prescription recommended or initially written by a Nephrologist?
4. Is the diagnosis or indication for treatment in adult patients with moderately-to severely-active rheumatoid arthritis in combination with methotrexate?
5. Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel is important to this review?

Physician's Signature: NPI/DEA #: Date:

For Internal Use Only
Approved Denied Reviewer's Initials Decision Date
Comments

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information. Our response time for prescription drug coverage requests is 72 hours. View our formulary and Prior Authorization forms online at http://www.scanhealthplan.com.