

- Preferred drug accepted. New verbal order authorized.
- Preferred drug rejected by physician.

Health New England
Medication Request Form (MRF)/Prescription Request
Rituxan ® (rituximab)

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

Prior Authorization

- Prior Authorization Only**
- Prior Authorization and Drug Delivery Request**

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

Instructions:

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Rituxan ®. Please complete this form and fax to ICORE Healthcare at (866)-364-2673. If you have any questions regarding this process, please contact ICORE Healthcare at (800) 775-5138.

J-Code: J9310, units are either 1 (100mg dose); 5 (500mg dose); or 10 (1000mg dose) To ensure proper payment; please use correct J-Code.

Medication Request Information (please complete each section of this form prior to transmittal):

Patient Information (all required)	Physician Information (all required)
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Patient Name:	Physician Name:
	Specialty:
Patient Cell Phone #: () -	NPI #:
Patient HNE ID#:	HNE Provider #:
Patient Date of Birth:	DEA # :
Allergies:	Telephone #: () -
Diagnosis:	Fax #: () -

Drug Information

Preferred Drug: <input type="checkbox"/> Humira <input type="checkbox"/> Enbrel		
Requested Drug/Strength/Form:		
Dose, Directions, and length of treatment (please be specific):	Quantity (per month):	Refills:
Physician Signature:	Date:	

Indication:

- Non-Hodgkin's lymphoma (NHL)
- Moderate to Severe Rheumatoid Arthritis **Initial treatment** **Repeat treatment - Date of last treatment:**
- Other (please describe): _____

Documentation of Medical Necessity (check all that apply):

- Therapy has been initiated or recommended by a hematologist/oncologist
- Therapy has been initiated or recommended by a rheumatologist
- Patient is intolerant to or failed at least one (1) trial with a DMARD or immunomodulator
- Failure or inadequate response to one or more tumor necrosis factor antagonists (Enbrel, Humira, Remicade) or Kineret
- Patient will be receiving methotrexate in combination with Rituxan
- Patient is intolerant to methotrexate or methotrexate is contraindicated in this patient
- Pregnancy has been excluded and if female is of child-bearing age appropriate contraception is being utilized
- Active infections have been excluded (including histoplasmosis, CMV, tuberculosis, HIV and local infections)
- Patient does NOT have progressive multifocal leukoencephalopathy (PML)
- For continuation of therapy, patient has demonstrated a clinical response to treatment
- Other pertinent history: _____