CIGNA®

Pharmacy Services

Phone: (800)244-6224
Fax: (800)390-9745

CIGNA HealthCare Prior Authorization Form
- Rituxan (rituximab) -

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

PROVIDER INFORMATION			PATIENT INFORMATION		
* Provider Name:			**Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed**		
Specialty:	* DEA or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* CIGNA ID:		
Office Fax:			* Date Of Birth:		
* Is your fax machine kept in a secure location? Yes ☐ No ☐ * May we fax our response to your office? Yes ☐ No ☐			* Patient Street Address:		
Office Street Address:			City	State	Zip
City	State	Zip	Patient Phone:		

Medication requested:

☐ Rituxan (rituximab) 10mg/ml vial

Dose and Quantity: Duration of therapy: J-Code:

Where will this medication be obtained?

☐ CIGNA Tel-Drug *(CIGNA's nationally preferred specialty pharmacy)*
☐ Retail pharmacy
☐ Prescriber's office stock (billing on a medical claim form)
☐ Home Health / Home Infusion vendor
☐ Other (please specify):

Diagnosis related to use (please specify):

☐ Rheumatoid Arthritis
☐ Non-Hodgkin's Lymphoma
☐ relapsed/refractory Waldenstrom's macroglobulinemia
☐ immune or idiopathic thrombocytopenic purpura
☐ Relapsed/refractory chronic lymphocytic leukemia
☐ Other (please specify):

Rheumatoid Arthritis:

Does the patient have a history of positive clinical response to Rituxan therapy?

☐ Yes ☐ No

Please indicate if the patient has had evidence of failure, inadequate response, intolerance or contraindication to any of the following disease-modifying anti-rheumatic drugs (DMARDs). Please check all that apply:

☐ Methotrexate ☐ Azathioprine ☐ Gold ☐ Hydroxychloroquine
☐ Penacillamine ☐ Sulfasalazine ☐ Other (please specify):

Which of the following methods was used to measure the patient's disease progression **PRIOR** to therapy on Rituxan? (Check all that apply):

☐ Health Assessment Questionnaire Disease Index (HAQ-DI)
☐ Visual Analogue scale (VAS)
☐ Likert scales of global response to pain by the patient/doctor
☐ Global Arthritis Score (GAS)
☐ Clinical Disease Activity Index (CDAI)
☐ Simplified Disease Activity Index (SDAI)
☐ Progression of radiographic damage of involved joints
☐ Disease Activity Scale (DAS) score
☐ Disease Activity Score based on 28-joint evaluation (DAS28) score Disease Activity Scale (DAS) score
☐ Elevation of ESR (> 28 mm/hr), or C-reactive protein (CRP) (2x the upper limit of normal)
☐ Other (please specify) :

(Continued on page 2)

Rheumatoid Arthritis (continued):

Has the patient had inadequate response, intolerance or contraindication to any of following Tumor Necrosis Factor (TNF) Antagonists?

☐ Humira (adalimumab) ☐ Enbrel (etanercept) ☐ Remicade (infliximab)

If this is a request for **CONTINUED THERAPY** (after at least 16 weeks of treatment), has the patient shown positive response to treatment with Kineret based on any of the following measurements? (Check all that showed a positive response to Kineret therapy):

☐ Health Assessment Questionnaire Disease Index (HAQ-DI)
☐ Likert scales of global response to pain by the patient/doctor
☐ Clinical Disease Activity Index (CDAI)
☐ Progression of radiographic damage of involved joints
☐ Disease Activity Score based on 28-joint evaluation (DAS28) score Disease Activity Scale (DAS) score
☐ At least a 20% improvement according to ACR 20% response criteria
☐ Other (please specify) :

☐ Visual Analogue scale (VAS)
☐ Global Arthritis Score (GAS)
☐ Simplified Disease Activity Index (SDAI)
☐ Disease Activity Scale (DAS) score
☐ ESR or C-reactive protein (CRP)

Additional pertinent information:

CIGNA HealthCare's coverage position on this and other medications may be viewed online at: http://www.cigna.com/customer_care/healthcare_professional/coverage_positions

Please fax completed form to (800)390-9745. Phone requests may be submitted by calling (800)244-6224.

Our standard response time for prescription drug coverage requests is 2-4 business days. If your request is urgent, it is important that you call Pharmacy Services to expedite the request. View our formulary on line at http://www.cigna.com.

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