AmWINS Rx

Date of Request:____________________

Sterling Retiree Rx Prior Authorization Form

RITUXAN (Rituximab)

Coverage Criteria / Required Medical Information
Prescriber must be Rheumatologist or Oncologist.

Rheumatoid Arthritis: inadequate response to a nonbiologic DMARD (8-week trial) **and** inadequate response to either Enbrel or Humira.
Chronic Lymphocytic Leukemia and Adult Acute Lymphoblastic Leukemia: Rituxan must be used in combination with chemotherapy.

Continuation of Therapy: improvement in clinical symptoms of RA required - may include improvement in tender and swollen joint count, mobility, or stiffness, or delay in progression of disease

Coverage Duration: 6 months
.
Exclusion Criteria
Hypersensitivity to murine proteins or chimeric monoclonal antibodies **or** patient is receiving live vaccines

Member Information					
Name					
Enrollment/Card-holder ID Number					
Group/Plan		Male		Female	
Date of Birth		Age		Weight in Kg	
Street Address					
City		State		Zip	

Physicians Information					
Name					
Agent		Contact Name			
Specialty/Office					
Clinic Name					
Street Address					
City		State		Zip	
Phone		Fax			

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Sterling Retiree Rx Prior Authorization Form

Requested Drug			
RITUXAN	Reason for Request		
Condition/Diagnosis Related			
Clinical Drug/Lab History Pertinent to Request			
Labs: Baseline/Ongoing	Strength/Dosage		
Formulary Alternative(s) Attempted?	Yes:	No:	
Please List Alternative Formulary Drugs			
Comments			

Physicians Signature: ____ Fax Form to 1-866-481-3704