Prescription Drug Coverage Determination Form
Monoclonal Antibody
Rituxan® (rituximab)

Please fax the completed form to Mercy Health Plans' Pharmacy Department
at 314-214-8201 or 1-800-466-9854.

Patient Information
Patient Name: _______________ Date of Birth:__________________
Subscriber ID#: __________________
Address______________________City_______________State____Zip Code________

Physician Information
Name: ______________________ Specialty:____________Tax ID#: _______________
Office Address______________________City__________State____Zip Code________
Telephone: _________________ Fax:__________________Contact Person___________

Physician Signature (REQUIRED):____________________________Date___________

Medication Information (requests for non-formulary agents will be considered for members having a documented failure or contraindication to preferred agents.)
Medication name:___________________ J-code:______________
Dose:_________________________________ Directions:________________________
Expected Duration of Therapy:_____________________

Prior Authorization Criteria:

1. Is the medication being requested to treat an FDA-approved indication not otherwise excluded from Part D? □ Yes □ No
   Diagnosis: ____________________________ ICD-9 code_______________
2. Does the patient have a diagnosis of Chronic Lymphocytic Leukemia (CLL)? □ Yes □ No
3. Does the patient have a diagnosis of Immune thrombocytopenic purpura (ITP)? □ Yes □ No
   If yes:
   - Has the patient demonstrated an inadequate response to first line treatments with corticosteroids and/or IVIG? □ Yes □ No
4. Does the patient have a diagnosis of Waldenstrom's macroglobulinemia? □ Yes □ No
5. Does the patient have a diagnosis of Non-Hodgkin's Lymphoma (NHL)? □ Yes □ No
   If yes, does the patient fall into one of the following categories:
   - CD20+ B-cell NHL; relapsed/refractory, low-grade or follicular? □ Yes □ No
   - Previously untreated follicular in combination with CVP chemotherapy? □ Yes □ No
   - Low grade in patients with stable disease or who achieve a partial or complete response following first-line treatment with CVP chemotherapy? □ Yes □ No
   - Diffuse large B-cell, treated first line in combination with CHOP or other □ Yes □ No

anthracycline-based chemotherapy?		
▪ Relapsed or refractory diffuse large B-cell lymphoma?	□ Yes	□ No
6. Has the patient been assessed for risk of active hepatitis B infection?	□ Yes	□ No
7. Is the patient currently being treated with another biologic DMARD		
If yes:	□ Yes	□ No
▪ Will the biologic DMARD be discontinued prior to initiation or rituximab therapy?	□ Yes	□ No

Please provide any additional history or medical information that may support coverage (attach office notes as necessary): ____

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Note: If approved coverage will be as specified in above criteria or through the end of the year (December 31, 20xx). Some medications may be subject to quantity limitations or restricted to certain pharmacies.