



Date of Request: _____

Sterling Retiree Rx Prior Authorization Form

RITUXAN (Rituximab)

Coverage Criteria / Required Medical Information

Non-Hodgkin Lymphoma (NHL); Rheumatoid Arthritis (RA)

For RA, use in combination with methotrexate in adults with moderate to severe active RA who have had an inadequate response to one or more TNF-antagonists.

Patient must be assessed for the risk of hepatitis B and, if clinically indicated, tested for hepatitis B infection before initiation or continuation of therapy with Rituxan.

Exclusion Criteria

RA - Rituxan cannot be used concomitantly with another biologic DMARD

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		

Requested Drug

RITUXAN		Reason for Request			
Condition/Diagnosis Related					

Clinical Drug/Lab History Pertinent to Request

Labs: Baseline/Ongoing		Strength/Dosage	
Please List Alternative Formulary Drugs			

Comments					
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Physicians Signature: _____

Fax Form to 1-877-847-9904