



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 <input type="checkbox"/> No <input type="checkbox"/>			* Patient Street Address:		
* May we fax our response to your office? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Office Street Address:			City	State	Zip
City	State	Zip	Patient Phone:		
Medication requested:					
<input type="checkbox"/> Rituxan (rituximab) 10mg/ml vial					
Dose and Quantity:		Duration of therapy:		J-Code:	
Where will this medication be obtained?					
<input type="checkbox"/> CIGNA Tel-Drug (CIGNA's nationally preferred specialty pharmacy)			<input type="checkbox"/> Retail pharmacy		
<input type="checkbox"/> Prescriber's office stock (billing on a medical claim form)			<input type="checkbox"/> Home Health / Home Infusion vendor		
<input type="checkbox"/> Other (please specify):					
Diagnosis related to use (please specify):					
<input type="checkbox"/> Rheumatoid Arthritis		<input type="checkbox"/> Non-Hodgkin's Lymphoma			
<input type="checkbox"/> relapsed/refractory Waldenstrom's macroglobulinemia			<input type="checkbox"/> immune or idiopathic thrombocytopenic purpura		
<input type="checkbox"/> Relapsed/refractory chronic lymphocytic leukemia			<input type="checkbox"/> Other (please specify):		
Rheumatoid Arthritis:					
Does the patient have a history of positive clinical response to Rituxan therapy?					
<input type="checkbox"/> Yes <input type="checkbox"/> 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:					
<input type="checkbox"/> Methotrexate		<input type="checkbox"/> Azathioprine		<input type="checkbox"/> Gold	
<input type="checkbox"/> Penicillamine		<input type="checkbox"/> Sulfasalazine		<input type="checkbox"/> Hydroxychloroquine	
<input type="checkbox"/> 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):					
<input type="checkbox"/> Health Assessment Questionnaire Disease Index (HAQ-DI)			<input type="checkbox"/> Visual Analogue scale (VAS)		
<input type="checkbox"/> Likert scales of global response to pain by the patient/doctor			<input type="checkbox"/> Global Arthritis Score (GAS)		
<input type="checkbox"/> Clinical Disease Activity Index (CDAI)			<input type="checkbox"/> Simplified Disease Activity Index (SDAI)		
<input type="checkbox"/> Progression of radiographic damage of involved joints			<input type="checkbox"/> Disease Activity Scale (DAS) score		
<input type="checkbox"/> Disease Activity Score based on 28-joint evaluation (DAS28) score Disease Activity Scale (DAS) score					
<input type="checkbox"/> Elevation of ESR (> 28 mm/hr), or C-reactive protein (CRP) (2x the upper limit of normal)					
<input type="checkbox"/> 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):

- | | |
|--|---|
| <input type="checkbox"/> Health Assessment Questionnaire Disease Index (HAQ-DI) | <input type="checkbox"/> Visual Analogue scale (VAS) |
| <input type="checkbox"/> Likert scales of global response to pain by the patient/doctor | <input type="checkbox"/> Global Arthritis Score (GAS) |
| <input type="checkbox"/> Clinical Disease Activity Index (CDAI) | <input type="checkbox"/> Simplified Disease Activity Index (SDAI) |
| <input type="checkbox"/> Progression of radiographic damage of involved joints | <input type="checkbox"/> Disease Activity Scale (DAS) score |
| <input type="checkbox"/> Disease Activity Score based on 28-joint evaluation (DAS28) score | <input type="checkbox"/> Disease Activity Scale (DAS) score |
| <input type="checkbox"/> At least a 20% improvement according to ACR 20% response criteria | <input type="checkbox"/> ESR or C-reactive protein (CRP) |
| <input type="checkbox"/> Other (please specify) : | |

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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