



Date of Request _____

RITUXAN - rituximab

Member Information

Name _____
Enrollment / Cardholder ID _____
Group / Plan _____
Birth Date _____
Address _____
City State Zip _____

Relationship (Circle)

Subscriber Spouse Dependent
Gender (Circle)
Male Female
AGE: _____

Practitioner Information

Name _____
Agent / Contact Name _____
Specialty _____
Office / Clinic Name _____
Address _____
City State Zip _____
Phone () - _____
Fax () - _____
Email _____ @ _____

Primary Diagnosis Condition /
Diagnosis Related - Reason for Request

- Diagnosis of relapsed or refractory, low-grade or follicular, CD20-positive, B-cell NHL
First-line treatment of follicular, CD20-positive, B-cell NHL in combination with cyclophosphamide, vincristine, and prednisone chemotherapy
Treatment of low-grade, CD20-positive, B-cell NHL in patients with stable disease or who achieve a partial or complete response following first-line treatment with cyclophosphamide, vincristine, and prednisone chemotherapy
First-line treatment of diffuse large B-cell, CD20-positive NHL in combination with cyclophosphamide, doxorubicin, vincristine, and prednisone, or other anthracycline-based chemotherapy regimens
Rheumatoid arthritis:
Does the patient have a diagnosis of moderate to severe RA? Y/N
Documented inadequate response to 1 or more tumor necrosis factor (TNF) antagonist therapies [Humira (ADALIMUMAB), Enbrel (ETANERCEPT), Remicade (INFLIXIMAB)]. Please define:
Is the patient on methotrexate therapy or has had an inadequate response to methotrexate after 3-6 months or the patient has a contraindication to methotrexate therapy. Please define:
Does the patient have a negative PPD test within the past year? Y/N

Strength / Dose

Duration of Therapy (Expected)

Formulary Alternatives
Attempted/Outcome

Clinical Drug / Lab History Pertinent to Request

Contact Pharmacy? Y N
Pharmacy Phone Number

Practitioner Signature

Date Received: _____
Reviewed By: _____
Forwarded To: _____

FAX Form to
877-800-5633