EXPRESS SCRIPTS®

Clear Print

Prior Authorization Request

RITUXAN, RITUXAN SC, RIABNI, RIXIMYO, RUXIENCE, TRUXIMA (rituximab)

Instructions

Please complete Part A and have your physician complete Part B. Completion and submission is not a guarantee of approval. Any fees related to the completion of this form are the responsibility of the plan member. Drugs in the Prior Authorization Program may be eligible for reimbursement if the patient does not qualify for coverage under a primary plan or a government program. Drugs used for indications not approved by Health Canada may be denied. For Quebec plan members, RAMQ exception drug criteria may apply. The decision for approval versus denial is based on pre-defined clinical criteria, primarily based on Health Canada approved indication(s) and on supporting evidence-based clinical protocols. The plan member will be notified whether their request has been approved or denied. Please note that you have the right to appeal the decision made by Express Scripts Canada.

Part A – Patient

Patient information

First Name:	Last Name:	
Insurance Carrier Name/Number:		
Group Number:	Client ID:	
Date of Birth (YYYY/MM/DD):	Relationship: ☐ Employee ☐ Spouse ☐ Dependent	
Language: ☐ English ☐ French	Gender: ☐ Male ☐ Female	
Address:		
City:	Province:	Postal Code:
Email address:		
Telephone (home):	Telephone (cell):	Telephone (work):

Coordination of benefits

Patient Assistance Program	Is the patient enrolled in any patient assistance program? ☐ Yes ☐ No Contact Name: _____ Fax: _____
Provincial Coverage	Has the patient applied for reimbursement under a provincial plan? ☐ Yes ☐ No ☐ N/A What is the coverage decision of the drug? ☐ Approved ☐ Denied ***Attach decision letter****
Primary Coverage	Has the patient applied for reimbursement under a primary plan? ☐ Yes ☐ No ☐ N/A What is the coverage decision of the drug? ☐ Approved ☐ Denied ***Attach decision letter****

Authorization

On behalf of myself and my eligible dependents, I authorize my group benefit provider, and its agents, to exchange the personal information contained on this form. I give my consent on the understanding that the information will be used solely for purposes of administration and management of my group benefit plan. This consent shall continue so long as my dependents and I are covered by, or are claiming benefits under the present group contract, or any modification, renewal, or reinstatement thereof.

_____ _____

Plan Member Signature Date

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Part B – Prescriber

Please see instructions on page 1 and complete all sections below. Incomplete forms may result in automatic denial. Please do **not** provide genetic test information or results.

SECTION 1 – DRUG REQUESTED

☐ RITUXAN	☐ RITUXAN SC	☐ RIABNI	☐ New request
☐ RIXIMYO	☐ RUXIENCE	☐ TRUXIMA	☐ Renewal request*

Dose	Administration (ex: oral, IV, etc)	Frequency	Duration

Site of drug administration:

☐ Home ☐ Physician's office/Infusion clinic ☐ Hospital (outpatient) ☐ Hospital (inpatient)

* Please submit proof of prior coverage if available

SECTION 2 – ELIGIBILITY CRITERIA

1. Please indicate if the patient satisfies the below criteria:

Rheumatoid Arthritis

- ☐ For the treatment of moderately to severely active rheumatoid arthritis in an adult, AND
- ☐ The patient has had an inadequate response to a minimum 12-week trial of methotrexate in combination with another disease modifying anti-rheumatic drug (DMARD) *(Please list prior therapies in the chart below)*, OR
- ☐ Where combinations of non-biologic DMARDs are impossible, the patient has tried 3 consecutive non-biologic DMARDs, unless patient has a documented intolerance to DMARDs *(Please list prior therapies in the chart below)*, AND
- ☐ The patient has tried and failed another biologic response modifier *(Please list prior therapies in the chart below)*, AND
- ☐ Rituximab IV will be used in combination with methotrexate or other DMARDs unless there is a documented intolerance

Non-Hodgkin's Lymphoma – *Eligibility based on plan design*

- ☐ For the treatment of non-Hodgkin's lymphoma in an adult, AND
- ☐ The patient has relapsed or refractory low-grade or follicular, CD20 positive, B-cell non-Hodgkin's lymphoma and will use rituximab IV formulation only, OR
- ☐ The patient has CD20 positive, diffuse large B-cell non-Hodgkin's lymphoma and rituximab will be used in combination with CHOP (cyclophosphamide, doxorubicin, vincristine, and prednisone) chemotherapy, OR
- ☐ The patient has previously untreated stage III/IV follicular, CD20 positive, B-cell non-Hodgkin's lymphoma and rituximab will be used in combination with CVP (cyclophosphamide, vincristine, and prednisone) chemotherapy, OR
- ☐ The patient has follicular non-Hodgkin's lymphoma and has responded to induction therapy with either CHOP or CHOP plus rituximab and requires maintenance treatment, OR
- ☐ The patient has previously untreated, advanced follicular non-Hodgkin's lymphoma with high tumour burden and has responded to induction therapy with either CHOP plus rituximab or CVP plus rituximab and requires single-agent maintenance treatment

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Chronic Lymphocytic Leukemia – *Eligibility based on plan design*

- ☐ For the treatment of chronic lymphocytic leukemia (CLL) in an adult, AND
- ☐ The patient has B-cell chronic lymphocytic leukemia (B-CLL), Binet Stage B or C, AND
- ☐ Rituximab will be used in combination with fludarabine and cyclophosphamide

Granulomatosis with Polyangiitis and Microscopic Polyangiitis

- ☐ For the induction of remission in severely active granulomatosis with polyangiitis (GPA, also known as Wegener's granulomatosis) or microscopic polyangiitis (MPA) in an adult, AND
- ☐ The patient will be using rituximab IV in combination with glucocorticoids, AND
- ☐ The patient has had an inadequate response or has a documented intolerance to cyclophosphamide *(Please list prior therapies in the chart below)*

OR

- ☐ None of the above criteria applies.

Relevant additional information:

2. Please list previously tried therapies

Drug	Dosage and administration	Duration of therapy		Reason for cessation	
		From	To	Inadequate response	Allergy/ Intolerance
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

3. Additional criteria for RITUXAN IV requests

- ☐ The patient is intolerant to, or had a confirmed adverse event with a biosimilar *(Please indicate in the chart above)*

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SECTION 3 – PRESCRIBER INFORMATION

Physician's Name:	
Address:	
Tel:	Fax:
License No.:	Specialty:
Physician Signature:	Date:

Please fax or mail the completed form to Express Scripts Canada®

Fax: Express Scripts Canada Clinical Services
1 (855) 712-6329

Mail: Express Scripts Canada Clinical Services
6985 Financial Drive, Suite 300
Mississauga, ON, L5N 0G3