Fax Referral To: 800-323-2445
Phone: 866-278-6634

Rituxan® (rituximab)
Enrollment Form
For Blue Cross Blue Shield of Rhode Island Members

Date: __________ **Needs by Date (Please Specify):** __________

Ship to: ☐ Patient ☐ Office ☐ Other: ____________________

PATIENT INFORMATION		PRESCRIBER INFORMATION	
*(Complete the following or **send patient demographic sheet**)*		Prescriber's Name:	
Patient Name:		State License #:	UPIN:
Address:		DEA #:	NPI #:
City, State, Zip:		Group or Hospital:	
Home Phone:		Address:	
Alternate Phone:		City, State Zip:	
Last Four of SS #:	Primary Language:	Phone:	Fax:
Date of Birth:	Gender:	Contact Person:	Phone:

INSURANCE INFORMATION (*Please copy and attach the front and back of insurance and prescription drug card*)

Prescription Card:	Name of Insurer:	ID#:	BIN: PCN:	Group:
Primary Insurance:	Subscriber:	ID#:	Name of Insurer: Blue Cross Blue Shield of RI	Phone:
Secondary Insurance:	Subscriber:	ID#:	Name of Insurer:	Phone:

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Diagnosis (ICD-9 code): ☐ 714.0 Rheumatoid Arthritis ☐ Other: ____________ • Date of Diagnosis: ________

APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

- Patient has the diagnosis of Rheumatoid Arthritis (adult) **AND** ☐ Yes ☐ No
  - Patient is 18 years of age or older **AND** ☐ Yes ☐ No
  - Patient has a diagnosis of moderately to severely active rheumatoid arthritis **AND** ☐ Yes ☐ No
  - Patient is currently taking methotrexate ☐ Yes ☐ No
    - If no, does patient have a contraindication or other reason for not taking methotrexate? ☐ Yes ☐ No
    - Please provide contraindication/other reason: ____________________
  - Patient has had an inadequate response to 2 TNF blockers ☐ Yes ☐ No
    - If no, does patient have a contraindication or intolerance to 2 TNF blockers? ☐ Yes ☐ No
- Patient has the diagnosis of CD20-positive, B-cell non-Hodgkin's lymphoma ☐ Yes ☐ No
- Patient has a diagnosis of CD20-positive chronic lymphocytic leukemia (CLL) ☐ Yes ☐ No
- Patient has a diagnosis of Wegener's granulomatosis or microscopic polyangiitis ☐ Yes ☐ No
- Patient has a diagnosis of relapsed/refractory Waldenstrom's macroglobulinemia ☐ Yes ☐ No
- Patient has a diagnosis of immune or idiopathic thrombocytopenic purpura ☐ Yes ☐ No

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Rituxan® (rituximab)	☐ 100mg/10ml vial ☐ 500mg/50ml vial	☐ Infuse two doses of 1000mg in 1 liter of 0.9% NaCl separated by 2 weeks. ☐ Other: ____________		

X ____________________ PRODUCT SUBSTITUTION PERMITTED (Date)

X ____________________ DISPENSE AS WRITTEN (Date)

IMPORTANT NOTICE: *This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. Rituxan PAB 093011*