

RITUXAN FOR RHEUMATOID ARTHRITIS PRIOR REVIEW FAXBACK FORM

| PRESCRIBER INFORMATION | | PATIENT INFORMATION | |
|------------------------|---|---------------------|-----|
| PRESCRIBER NAME | PROVIDER ID/TAX ID <small>(if out of state must have tax ID)</small> | PATIENT NAME | |
| CONTACT PERSON | | BCBSNC ID | |
| PRESCRIBER PHONE | PRESCRIBER FAX | DATE OF BIRTH | |
| PRESCRIBER ADDRESS | CITY | STATE | ZIP |

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Will the patient be receiving treatment with more than one biologic rheumatoid arthritis agent (Enbrel, Humira, Kineret, Remicade, Orencia or Rituxan) at the same time? Yes No
2. Does the patient have moderate to severe rheumatoid arthritis? Yes No
3. Has the patient received this drug within the last 6 months? Yes No
4. Has the patient failed to respond adequately to at least one Tumor Necrosis Factor (TNF) inhibiting drug (e.g., Remicade, Enbrel or Humira)? Yes No
5. Is the patient intolerant to **ALL** TNF-inhibiting drugs? Yes No
6. Is the patient receiving methotrexate? Yes No
7. Is the patient 18 years or older? Yes No

I certify that the above information is accurate and **is documented in the medical record.**

Prescriber's Signature Required: _____ Date _____

If treatment is approved, the coverage duration is 6 months.

For BCBSNC members, fax form to 1-800-795-9403

For NC State Health Plan members, fax form to 1-866-225-5258

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