

**NOTE:** Failure to respond within 36 business hours will result in a denial for lack of information.

## Rituxan (rituximab)



### Prior Authorization Request (Physician to Complete)

Visit [www.wellmark.com](http://www.wellmark.com) for the Wellmark Drug List for current medication tier levels and updated PA Forms

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#### Facsimile Transmittal Sheet

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

To: Wellmark Pharmacy Services

From (Prescriber's Name): \_\_\_\_\_

Fax Number: (866) 884-4345

Prescriber's DEA Number: \_\_\_\_\_

Phone Number: (800) 600-8065

Prescriber's Phone Number: \_\_\_\_\_

Prescriber's Specialty: \_\_\_\_\_

Prescriber's Fax Number: \_\_\_\_\_

Prescriber's Office Address: \_\_\_\_\_  
Street Suite # City State Zip

Patient Name: \_\_\_\_\_

Patient ID: \_\_\_\_\_ Patient DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please answer the following questions and fax this form back to (866) 884-4345. All fields are REQUIRED.

1. Please provide the diagnosis this therapy has been prescribed for: \_\_\_\_\_  
\_\_\_\_\_

ICD-9 Code: \_\_\_\_\_

2. Is the patient on concomitant methotrexate (MTX) therapy?  Yes  No

3. Has the patient shown inadequate response to any of the agents listed below?

Yes (check all that apply below)

Actemra (tocilizumab)

Cimzia (certolizumab)

Enbrel (etanercept)

Humira (adalimumab)

Kineret (anakinra)

Orencia (abatacept)

Remicade (infliximab)

Simponi (golimumab)

No (list any contraindications, if applicable): \_\_\_\_\_  
\_\_\_\_\_

4. Dose per injection/infusion: \_\_\_\_\_ mg Frequency of injection/infusion: \_\_\_\_\_ per \_\_\_\_\_

Printed Name

Signature

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