



**Rheumatoid Arthritis Medication Form**  
**Rituxan® Precertification Request**  
 (Please complete & return page 1 only.)  
 Page 1 of 2

**Aetna Precertification Notification**  
 503 Sunport Lane, Orlando, FL 32809  
 Phone: 1-866-503-0857  
 FAX: 1-888-267-3277

Please indicate:  Start of treatment  Continuation of therapy Today's date: \_\_\_\_\_ Date needed: \_\_\_\_\_

Dispensing Provider:  Aetna Specialty Pharmacy® or  Other: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ TIN: \_\_\_\_\_ PIN: \_\_\_\_\_

Ship to:  Doctor's office  Patient  Other: \_\_\_\_\_ Phone: \_\_\_\_\_

Precertification Requested By: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**A. PATIENT INFORMATION**

First Name: _____		Last Name: _____	
Address: _____		City: _____	State: _____ ZIP: _____
Home Phone: _____	Work Phone: _____	Cell Phone: _____	
DOB: _____	Allergies: _____	Email: _____	
Patient Current Weight: _____ lbs or _____ kgs		Patient Height: _____ inches or _____ cms	

**B. INSURANCE INFORMATION**

Aetna Member ID #: _____	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured: _____	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____

**C. PRESCRIBER INFORMATION**

First Name: _____	Last Name: _____		(Circle one): M.D. D.O. N.P. P.A.	
Address: _____	City: _____	State: _____	ZIP: _____	
Phone: _____	Fax: _____	St. Lic. #: _____	NPI #: _____	DEA #: _____ UPIN: _____
Provider Email: _____	Office Contact Name: _____		Phone: _____	
Specialty (Check one): <input type="checkbox"/> Rheumatologist <input type="checkbox"/> Other: _____				

**D. DIAGNOSIS INFORMATION**

Primary ICD-9: <input type="checkbox"/> _____ Rheumatoid Arthritis (714.0 – 714.9)	<input type="checkbox"/> 714.3 Juvenile Rheumatoid Arthritis	<input type="checkbox"/> 720.0 Ankylosing Spondylitis
<input type="checkbox"/> 696.0 Psoriatic Arthritis	<input type="checkbox"/> Other ICD-9 Code: _____	

**E. CLINICAL INFORMATION**

**Please check all that apply:**

<input type="checkbox"/> Rheumatoid Arthritis, Functional Class III or IV	<input type="checkbox"/> Cricoarytenoid Rheumatoid Arthritis
<input type="checkbox"/> Rheumatoid Arthritis with extra-articular manifestations	<input type="checkbox"/> Rheumatoid Arthritis with rapidly progressive severe systemic disease
<input type="checkbox"/> Rheumatoid Vasculitis	<input type="checkbox"/> Atlantoaxial (C1-C2) Subluxation
<input type="checkbox"/> Other _____	

**Previous Therapy:** (DMARDS including biologics)

Name of Medication _____	<input type="checkbox"/> Disease Progression?	<input type="checkbox"/> Adverse Rxn?	<input type="checkbox"/> Unable to tolerate?
Name of Medication _____	<input type="checkbox"/> Disease Progression?	<input type="checkbox"/> Adverse Rxn?	<input type="checkbox"/> Unable to tolerate?
Name of Medication _____	<input type="checkbox"/> Disease Progression?	<input type="checkbox"/> Adverse Rxn?	<input type="checkbox"/> Unable to tolerate?
Name of Medication _____	<input type="checkbox"/> Disease Progression?	<input type="checkbox"/> Adverse Rxn?	<input type="checkbox"/> Unable to tolerate?

**Current Therapy:** (DMARDS including biologics)

Name of Medication _____	<input type="checkbox"/> Disease Progression?	<input type="checkbox"/> Adverse Rxn?	<input type="checkbox"/> Unable to tolerate?	<input type="checkbox"/> D/C?
Name of Medication _____	<input type="checkbox"/> Disease Progression?	<input type="checkbox"/> Adverse Rxn?	<input type="checkbox"/> Unable to tolerate?	<input type="checkbox"/> D/C?
Name of Medication _____	<input type="checkbox"/> Disease Progression?	<input type="checkbox"/> Adverse Rxn?	<input type="checkbox"/> Unable to tolerate?	<input type="checkbox"/> D/C?

Yes  No Will this patient be taking methotrexate concurrently with Rituxan? If no, please indicate why not. \_\_\_\_\_

**F. PRESCRIPTION INFORMATION – To be completed as a prescription order if Aetna Specialty Pharmacy is Dispensing Provider**  
 (Refer to guide on Page 2.)

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS

\*If Aetna Specialty Pharmacy is the dispensing pharmacy, patient benefits will be verified before product is shipped.  
 \*If the prescriber is providing the drug, the provider must verify benefits.  
 Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 (Required by law if this Precertification Request is also used as an Aetna Specialty Pharmacy prescription order.)  
 Interchange is mandated unless practitioner writes the words "NO SUBSTITUTION" in this space: \_\_\_\_\_



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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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*\*This page is for informational purposes only.*

**PRESCRIPTION GUIDE CHART**

MEDICATION	STRENGTH	DIRECTIONS
<b>Cimzia®</b> CPB # 0761	- 200 mg lyophilized powder - 200 mg/ml single use pre-filled syringe	- Induction Dose: Inject 400mg SQ at weeks 0, 2 & 4 - Maintenance Dose: 200mg every 2 weeks, or - Maintenance Dose: 400mg every 4 weeks
<b>Enbrel®</b> CPB # 0315	- 25 mg multiple-use vial - 25 mg/0.5ml single-use pre-filled syringe - 50 mg/ml single-use pre-filled syringe - 50 mg/ml single-use pre-filled SureClick™ autoinjector	- Inject 50mg SQ ONCE a week - Inject 25mg SQ TWICE a week (72-96 hours apart) - Other: _____
<b>Humira®</b> CPB # 0655	- 40mg/0.8ml pre-filled syringe - 40 mg/0.8ml pen - 20mg/0.4ml pre-filled syringe - Other: _____	- Inject 40mg SQ every other week - Inject 20mg SQ every other week - Other: _____
<b>Kineret®</b> CPB # 0595	- 100 mg pre-filled syringe	- Inject 100mg (one syringe) SQ once a day
<b>Orencia®</b> CPB # 0720	- powder 250mg/15ml vial - Infusion supplies - 100ml 0.9% NaCl	- Infuse _____ mg in 100ml of 0.9% NaCl at weeks 0, 2 & 4, then every 4 weeks - Other: _____
<b>Remicade®</b> CPB # 0341	- 100mg single dose vials - _____ mg/kg - Infusion supplies - 250ml 0.9% NaCl	- Induction Dose: IV in 250ml of 0.9% NaCl at weeks 0, 2 & 6 weeks - Maintenance Dose: IV in 250ml of 0.9% NaCl every 8 weeks - Maintenance Dose: IV in 250ml of 0.9% NaCl every 6 weeks - Other: _____
<b>Rituxan®</b> CPB # 0314	- 100mg/10ml vial - 500mg/50mg vial - 100mg Methyprednisolone - Other: _____ - Infusion supplies - 1 liter 0.9% NaCl	- Infuse two doses of 1000mg in 1 liter of 0.9% NaCl separated by 2 weeks - Other: _____
<b>Simponi®</b> (golimumab)	- 50 mg/0.5ml single-use pre-filled syringe - 50 mg/0.5ml single-use pre-filled SmartJect™ autoinjector	- Inject 50mg SQ ONCE a month - Other: _____
<b>Methotrexate</b>	- 25mg/ml vial	- Inject _____ mg SQ/IM every _____ Indicate SQ/IM

**\*If Aetna Specialty Pharmacy is the dispensing pharmacy, patient benefits will be verified before product is shipped.**

**\*If the prescriber is providing the drug, the provider must verify benefits.**

**Prescriber's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
 (Required by law if this Precertification Request is also used as an Aetna Specialty Pharmacy prescription order.)

**Interchange is mandated unless practitioner writes the words "NO SUBSTITUTION" in this space:** \_\_\_\_\_