



Kansas Medical Assistance Program

P O Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593
Beneficiary 1-800-766-9012

**Rituximab (Rituxan®)
Prior Authorization Request Form**

Beneficiary Information

Beneficiary Name: _____
Beneficiary Medicaid ID #: _____ Date of Birth: ___/___/___

Billing Provider Information (Physician OR Facility)

Billing Provider's Name: _____
Provider Medicaid ID#: _____ Provider NPI#: _____
Phone Number: (____) _____ Fax Number: (____) _____
Procedure Code Requesting: _____ Total # of Units Requesting (per 6 months): _____

Prescriber Information

Prescriber's Name: _____
Prescriber's Medicaid ID#: _____ Prescriber's NPI#: _____
Phone Number: (____) _____ Fax Number: (____) _____

Requested Information

1. Please indicate the diagnosis and severity for which Rituxan® is being prescribed (no diagnosis codes):

2. What specialty is the prescriber? Rheumatologist _____ Oncologist _____
Hematologist _____ Other (please specify) _____
3. Is patient currently taking methotrexate? Yes _____ No _____
4. Is patient currently taking glucocorticoids? Yes _____ No _____
5. TB skin test results:
Date of test: ___/___/___ Positive _____ Negative _____
6. **For Rheumatoid Arthritis** – Please list previous therapies patient has tried and patient response to each therapy: _____

Renewals will require documentation of appropriate lab testing (including CBC and platelets)

Prescriber's Signature: _____ Date: ___/___/___

**Completed form should be faxed to the Prior Authorization Unit at 1-800-913-2229
This form will be returned unprocessed if it is not completed in its entirety.**