

**Request for Rituxan for Rheumatoid Arthritis (RA)  
Exceptional Access Program (EAP)**

Not for Other Inflammatory Disorders  
Not for Paediatric Cases



To avoid delays, please ensure that all appropriate information for each section is provided.

Section 1 - Physician Information			Section 2 - Patient Information		
First Name	Initial	Last Name	First Name	Initial	Last Name
Street #	Street Name		Ontario Health Insurance Number		
City	Postal Code		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Current Weight (kg)	
Fax	Telephone (Back Line)		Date of Birth (DD/MM/YYYY)		

REQUEST TYPE  
 Initial Request (Complete all sections)     Renewal Request (Complete sections 3, 4B)    EAP #

**Section 3 - Drug, Dose and Regimen Requested (attach additional sheets if more space is required)**

rituximab (Rituxan®)    1000 mg IV on day 0 and day 15. The second and subsequent course of rituximab in the approved year should only occur after an interval of at least 6 months and documentation of a loss of effect. Higher doses are not considered. Combinations of biologics will not be approved.

Section 4A Indication of Active Disease	Section 4B Response to Treatment									
<u>Diagnosis of active RA</u> <input type="checkbox"/> Failure of ≥ 1 TNF <input type="checkbox"/> ≥ 5 Swollen Joints <input type="checkbox"/> Rheumatoid Factor Positive and/or Anti-CCP Positive <b>AND/OR</b> <input type="checkbox"/> Radiographic Evidence of RA <i>if &lt; 5 swollen joints, provide location of swollen joints</i>	For rituximab renewals, provide swollen joint count pre-infusions, infusion dates, swollen joint count at 3-4 months post infusions and current swollen joint count. A course of rituximab should not occur without documentation of loss of effect.									
	Clinical Marker	Prior-to Requested Biologic	Post Rituxan	Pre Rituxan	Post Rituxan	Pre Rituxan	Post Rituxan	Pre Rituxan	Post Rituxan	Pre Rituxan
	Swollen Joint Count									
	Date (DD/MM/YYYY)									
	First Rituxan Infusion Dates (First date of last infusions) (DD/MM/YYYY)									

**Section 5 - Previous/Current Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy**

Provide details of use and response to treatment with Methotrexate (20 mg/wk) for at least 3 months and either leflunomide (20 mg/day) OR sulfasalazine (1gm twice daily) for at least 3 months, and must have failed 1 TNF. If patient has documented contraindications or intolerances to methotrexate, then only one of leflunomide or sulfasalazine for at least 3 months is required. Details of contraindications and intolerances must be provided.

PREVIOUS THERAPY	DOSING REGIMEN	START DATE (DD/MM/YYYY)	END DATE (DD/MM/YYYY)	REASON FOR DISCONTINUATION <small>Details of intolerance, contraindication, or failure at maximum dose must be provided</small>
methotrexate				
leflunomide				
TNF antagonist				

Physician Signature (Mandatory)	CPSO Number	Date (DD/MM/YYYY)
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Please fax the completed form and/or any additional relevant information to **416-327-7526** or toll free **1-866-811-9908**; or send to the Drug Programs Branch, 3rd Floor, 5700 Yonge Street, North York, Ontario, M2M 4K5. For copies of EAP forms, please visit: <http://ontariorheum.ca/drug-forms-and-codes/eap-forms>