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

Not for Other Inflammatory Disorders
Not for Paediatric Cases

Ontario Rheumatology Association

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

Section 1 - Physician Information

First Name	Initial	Last Name

Street #	Street Name

City	Postal Code

Fax	Telephone (Back Line)

Section 2 - Patient Information

First Name	Initial	Last Name

Ontario Health Insurance Number

Gender ◯ Male ◯ Female	Current Weight (kg)

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

Diagnosis of active RA

☐ Failure of ≥ 1 TNF

☐ ≥ 5 Swollen Joints

☐ Rheumatoid Factor Positive and/or Anti-CCP Positive

AND/OR

☐ Radiographic Evidence of RA

if < 5 swollen joints, provide location of swollen joints

Section 4B
Response to Treatment

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:

- Failure to respond to optimal use of DMARDs or documented intolerance or contraindications to DMARDs (per current EAP reimbursement criteria for antiTNF agents); **AND**
- Failure to respond to, or the patient has intolerance or contraindications to, an adequate trial of at least ONE anti-TNF agent (e.g., adalimumab, etanercept, infliximab, golimumab, certolizumab pegol)

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

Physician Signature (Mandatory)	CPSO Number	Date (DD/MM/YYYY)

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 Delivery 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