Rituxan Immunology and ACTEMRA Co-pay Card Program Verification of Administration

P.O. Box 2106, Morristown, NJ 07962
Phone: (855) 722-6729
Fax: (800) 334-3030
www.RACopay.com

As part of the request for patient reimbursement from The Rituxan Immunology and ACTEMRA Co-pay Card Program, please provide the below information for the date of service referenced on the explanation of benefits (EOB), if the EOB does not clearly state that this patient received Rituxan or ACTEMRA at your site on the specified date of service.

Patient name:	Member ID number:
Date of birth:	Today's Date:
Primary contact's name (office financial manager):	Primary contact's title:
Primary contact's phone number:	Primary contact's fax number:
Physician name(s):	

Please provide the following information so we can determine the patient's out-of-pocket responsibility for Rituxan or ACTEMRA.

Date of service: _____

Rituxan
Number of vials administered: _____ 100-mg dose _____375-mg dose _____500-mg dose
Total dose administered: _____
Total dose administered is reflective of the amount dispensed and does not include wastage.

Drug Billed Amount: $_____ Administration Billed Amount: $_____

ACTEMRA IV
Number of vials administered: _____ 80-mg dose _____200-mg dose _____400-mg dose
Total dose administered: _____
Total dose administered is reflective of the amount dispensed and does not include wastage.

Drug Billed Amount: $_____

Authorization	
Physician or office manager name:	Title:
Signature:	

Please fax this form back to (800) 334-3030 as soon as possible. We may be contacting you for additional information or clarification to determine patient eligibility. If you have any questions, please call (855) 722-6729.

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