MEDICARE FORM

Riabni® (rituximab-arrx), Rituxan® (rituximab), Ruxience (rituximab-pvvr), Truxima (rituximab-abbs) Medication Precertification Request

(All fields must be completed and return both pages for precertification review.)

For Medicare Advantage Part B:
Phone: 1-866-503-0857 **(TTY:** 711**)**
FAX: 1-844-268-7263

For other lines of business:
Please use other form.

Note: Riabni and Rituxan are non-preferred. The preferred products are Ruxience and Truxima. For rheumatoid arthritis, all Rituxan and biosimilar products are non-preferred.

Please indicate: ☐ Start of treatment, start date: ___/___/___ ☐ Continuation of therapy, date of last treatment: ___/___/___

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

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

B. INSURANCE INFORMATION

Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check 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:	

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office ☐ Home
☐ Outpatient Infusion Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

Dispensing Provider/Pharmacy:
☐ *Outpatient Dialysis Center* ☐ Physician's Office
☐ Retail Pharmacy ☐ Specialty Pharmacy
☐ Mail Order ☐ Other: _____
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

E. PRODUCT INFORMATION

Request is for: ☐ **Riabni (rituximab-arrx)** ☐ **Rituxan (rituximab)** ☐ **Ruxience (rituximab-pvvr)** ☐ **Truxima (rituximab-abbs)**
Dose: _____ **Directions for Use:** _____ **HCPCS Code:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other any other where applicable (*).

Primary ICD Code: _____ ☐ Other ICD Code: _____

G. CLINICAL INFORMATION - Required clinical information must be completed for ALL precertification requests.

For Initiation Requests (clinical documentation required for all requests):

Note: Riabni and Rituxan are non-preferred. Ruxience and Truxima are preferred for most indications.
For rheumatoid arthritis, all Rituxan and biosimilar products are non-preferred. Inflectra, Remicade, Simponi Aria and unbranded infliximab are preferred for MA plans. Enbrel, Humira, Kevzara, Rinvoq, and Xeljanz/Xeljanz XR are preferred for MAPD plans.

☐ Yes ☐ No Has the patient had prior therapy with the requested product within the last 365 days?
☐ Yes ☐ No Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply)
☐ Ruxience (rituximab-pvvr) ☐ Truxima (rituximab-abbs)
Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis? (select all that apply) ☐ Ruxience (rituximab-pvvr) ☐ Truxima (rituximab-abbs)

_____

☐ Yes ☐ No Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply)
☐ Remicade (infliximab) ☐ Inflectra (infliximab-dyyb) ☐ Simponi Aria (golimumab) ☐ Unbranded infliximab
☐ Yes ☐ No Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply)
☐ Enbrel (etanercept) ☐ Humira (adalimumab) ☐ Kevzara (sarilumab) ☐ Rinvoq (upadacitinib) ☐ Xeljanz/Xeljanz XR (tofacitinib)
Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis? (select all that apply) ☐ Remicade (infliximab) ☐ Inflectra (infliximab-dyyb) ☐ Simponi Aria (golimumab) ☐ Unbranded infliximab

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aetna®

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(Continued)* - Required clinical information must be completed for ALL precertification requests.

Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis? (select all that apply)

☐ Enbrel (etanercept) ☐ Humira (adalimumab) ☐ Kevzara (sarilumab) ☐ Rinvoq (upadacitinib) ☐ Xeljanz/Xeljanz XR (tofacitinib)

_____

For All Requests (clinical documentation required for all requests):

☐ Yes ☐ No Will Rituxan (rituximab) be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, infliximab)?

Acute lymphoid leukemia

☐ Yes ☐ No Does the patient have a documented diagnosis of Philadelphia chromosome-negative acute lymphoid leukemia (ALL)?

☐ Yes ☐ No Is Rituxan (rituximab) being used as induction/consolidation therapy?

Autoimmune hemolytic anemia

☐ Yes ☐ No Does the patient have a documented diagnosis of refractory autoimmune hemolytic anemia?

Anti-neutrophil cytoplasmic antibody-associated (ANCA-associated) vasculitides

Please indicate which of the following applies to the patient: ☐ Wegener granulomatosis ☐ Churg-Strauss syndrome ☐ microscopic polyangiitis ☐ pauci-immune glomerulonephritis

☐ Yes ☐ No Will Rituxan (rituximab) be given in conjunction with glucocorticoids?

Autoimmune blistering diseases, corticosteroid-refractory

☐ Yes ☐ No Does the patient have a documented diagnosis of corticosteroid-refractory autoimmune blistering disease?

→ Please select which applies to the patient: ☐ pemphigus vulgaris ☐ pemphigus folliaceus ☐ bullous pemphigoid ☐ cicatricial pemphigoid ☐ epidermolysis bullosa acquisita ☐ paraneoplastic pemphigus ☐ None of the above

B-cell lymphomas

Please select which applies to the patient: ☐ AIDS-related B-cell lymphoma ☐ Burkitt lymphoma ☐ Diffuse large B-cell lymphoma ☐ Follicular lymphoma ☐ Gastric MALT lymphoma ☐ High-grade B-Cell lymphoma ☐ Mantle cell lymphoma ☐ Nodal marginal zone lymphoma ☐ Nongastric MALT lymphoma ☐ Primary cutaneous B-cell lymphomas ☐ Splenic marginal zone lymphoma ☐ Other: _____

Castleman's disease

☐ Yes ☐ No Does the patient have a documented diagnosis of multicentric Castleman's disease (angiofollicular lymph node hyperplasia)?

Central nervous system lymphomas

Please select which applies to the patient: ☐ leptomeningeal metastases from lymphoma ☐ primary CNS lymphoma ☐ none of the above

Chronic or small lymphocytic leukemia

Please select which applies to the patient: ☐ chronic lymphocytic leukemia (CLL) ☐ small lymphocytic leukemia ☐ none of the above

Cryoglobulinemia

☐ Yes ☐ No Does the patient have a documented diagnosis of cryoglobulinemia?

☐ Yes ☐ No Is there clinical documentation that the treatment with corticosteroids and other immunosuppressive agents was ineffective?

Graft versus host disease, chronic

☐ Yes ☐ No Is there a documentation that Rituxan (rituximab) being used as last-resort treatment for chronic graft versus host disease (GVHD)?

Hairy cell leukemia

Please select which applies to the patient: ☐ relapsed hairy cell leukemia ☐ refractory hairy cell leukemia ☐ none of the above

Heart and solid organ transplant

☐ Yes ☐ No Is there a documentation that Rituxan (rituximab) is being used for treatment or prevention (desensitization) of highly sensitized patients with antibody mediated rejection in heart transplant recipients and other solid organ transplant recipients?

→ Please select which applies to the patient: ☐ heart transplant recipient ☐ other solid organ transplant recipient

Immune checkpoint-inhibitor related encephalitis

Please identify which immune check-point inhibitor caused the encephalitis: ☐ Bavencio (avelumab) ☐ Imfinzi (durvalumab) ☐ Keytruda (pembrolizumab) ☐ Opdivo (nivolumab) ☐ Tecentriq (atezolizumab) ☐ Yervoy (ipilimumab) ☐ Other: _____

Immune or idiopathic thrombocytopenic purpura

☐ Yes ☐ No Does the patient have a documented diagnosis of refractory immune or idiopathic thrombocytopenic purpura (ITP)?

→ ☐ refractory immune thrombocytopenic purpura ☐ idiopathic thrombocytopenic purpura (ITP)

Kidney transplant, rejection prophylaxis

☐ Yes ☐ No Is Rituxan (rituximab) being used as rejection prophylaxis in sensitized kidney transplant recipients with donor specific antibodies?

Lymphocyte-predominant Hodgkin's lymphoma

☐ Yes ☐ No Does the patient have a documented diagnosis of lymphocyte-predominant Hodgkin's lymphoma?

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G. CLINICAL INFORMATION *(Continued)* - Required clinical information must be completed for ALL precertification requests.

Multiple Sclerosis

Please indicate the type of multiple sclerosis the patient has been diagnosed with:

☐ Relapsing-remitting MS (RRMS) ☐ Secondary-progressive MS (SPMS) ☐ Primary-progressive MS (PPMS) ☐ Progressive-relapsing MS (PRMS)

☐ Yes ☐ No Has the patient discontinued other medications used for treating MS (not including Ampyra)?

Myasthenia gravis (MuSk-MG)

☐ Yes ☐ No Does the patient have a documented diagnosis of muscle-specific tyrosine kinase myasthenia gravis (MuSK-MG)?

→ ☐ Yes ☐ No Has the patient had an unsatisfactory response to initial immunotherapy?

Neuromyelitis optica (Devic's disease)

☐ Yes ☐ No Does the patient have a documented diagnosis of neuromyelitis optica (Devic's disease)?

☐ Yes ☐ No Was the treatment with at least one immunotherapy ineffective?

Opsoclonus-myoclonus-ataxia (opsoclonus myoclonus syndrome)

☐ Yes ☐ No Does the patient have a documented diagnosis of opsoclonus-myoclonus-ataxia (OMA) associated with neuroblastoma?

☐ Yes ☐ No Is the patient refractory to steroids, chemotherapy and intravenous immunoglobulins?

→ Please provide the names and date ranges of medications tried:

Medication: _____ Dates: ___/___/___ - ___/___/___

Medication: _____ Dates: ___/___/___ - ___/___/___

Post-transplant lymphoproliferative disorder

☐ Yes ☐ No Is Rituxan (rituximab) being used as treatment of post-transplant lymphoproliferative disorder?

→ ☐ Yes ☐ No Is Rituxan (rituximab) being used as prophylaxis for Epstein-Barr virus (EBV) post-transplant lymphoproliferative disorder?

Rheumatoid Arthritis

Please indicate the severity of the patient's rheumatoid arthritis: ☐ Mild ☐ Moderate ☐ Severe

☐ Yes ☐ No Is there evidence that the disease is active?

☐ Yes ☐ No Will Rituxan (rituximab) be used in combination with methotrexate?

→ ☐ Yes ☐ No Was treatment with methotrexate ineffective, not tolerated or contraindicated?

→ Please select: ☐ ineffective ☐ not tolerated ☐ contraindicated

→ ☐ Yes ☐ No Was treatment with another conventional DMARD ineffective?

→ Please select: ☐ azathioprine ☐ cyclosporine ☐ hydroxychloroquine ☐ leflunomide ☐ sulfasalazine

Sjögren syndrome

☐ Yes ☐ No Does the patient have a documented diagnosis of Sjögren's syndrome?

☐ Yes ☐ No Was treatment with corticosteroids and other immunosuppressive agents ineffective?

→ Please provide the names and dates of the corticosteroids and other immunosuppressive agents used:

Medication: _____ Dates: ___/___/___ - ___/___/___

Medication: _____ Dates: ___/___/___ - ___/___/___

Thrombotic thrombocytopenic purpura

☐ Yes ☐ No Does the patient have a documented diagnosis of refractory thrombotic thrombocytopenic purpura (TTP)?

Waldenstrom's macroglobulinemia

☐ Yes ☐ No Does the patient have a documented diagnosis of Waldenström macroglobulinemia?

For Continuation Requests:

☐ Yes ☐ No Is this continuation request a result of the patient receiving samples of Rituxan (rituximab)?

Please indicate the length of time on Rituxan (rituximab): _____

For rheumatoid arthritis only:

Please indicate the severity of the disease at baseline (pretreatment with Rituxan (rituximab): ☐ Mild ☐ Moderate ☐ Severe

☐ Yes ☐ No Is there clinical documentation supporting disease stability?

☐ Yes ☐ No Is there clinical documentation supporting disease improvement?

For all other indications:

☐ Yes ☐ No Is there clinical documentation supporting disease stability?

☐ Yes ☐ No Is there clinical documentation supporting disease improvement?

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required)*: _____ **Date:** ___/___/___

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.