



MEDICARE FORM

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

Page 1 of 3

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

For Michigan MMP: FAX: 1-844-241-2495 PHONE: 1-855-676-5772

For other lines of business: Please use other form.

Note: Rituxan, Rituxan Hycela, and Truxima are preferred. Riabni and Ruxience are non-preferred. 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

Form with fields for Patient Information: First Name, Last Name, DOB, Address, City, State, ZIP, Home Phone, Work Phone, Cell Phone, E-mail, Current Weight, Height, Allergies.

B. INSURANCE INFORMATION

Form with fields for Insurance Information: Member ID #, Group #, Insured, Does patient have other coverage?, Carrier Name, Insured.

C. PRESCRIBER INFORMATION

Form with fields for Prescriber Information: First Name, Last Name, Address, City, State, ZIP, Phone, Fax, St Lic #, NPI #, DEA #, UPIN, Provider Email, Office Contact Name, Phone.

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Form with fields for Dispensing Provider/Pharmacy: Place of Administration, Dispensing Provider/Pharmacy, Name, Address, City, State, ZIP, Phone, Fax, TIN, PIN, NPI.

E. PRODUCT INFORMATION

Form with fields for Product Information: Request is for, Dose, Directions for Use, HCPCS Code.

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

Form with fields for Diagnosis Information: Primary ICD Code, Other ICD Code.

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

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

Note: Rituxan, Rituxan Hycela, and Truxima are preferred for most indications. Riabni and Ruxience are non-preferred. For rheumatoid arthritis, all Rituxan and biosimilar products are non-preferred. Inflectra, Remicade, and Simponi Aria 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 Riabni (rituximab-arrx) or Ruxience (rituximab-pvvr) 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) [] Rituxan (rituximab) [] Rituxan Hycela (rituximab/hyaluronidase human) [] 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) [] Rituxan (rituximab) [] Rituxan Hycela (rituximab/hyaluronidase human) [] 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)

[] 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)

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)

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

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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G. CLINICAL INFORMATION (Continued) - Required clinical information must be completed for ALL precertification requests.

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 foliaceus 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?

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)?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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G. CLINICAL INFORMATION (Continued) - Required clinical information must be completed for ALL precertification requests.

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-myoelonus-ataxia (opsoclonus myoclonus syndrome)

Yes No Does the patient have a documented diagnosis of opsoclonus-myoelonus-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: ____/____/____ - ____/____/____
 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.