



MEDICARE FORM

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 Virginia HMO SNP:

FAX: 1-833-280-5224

PHONE: 1-855-463-0933

For other lines of business:

Please use other form.

Note: Rituxan is non-preferred for Rheumatoid Arthritis. Renflexis is the preferred product for MA plans and Humira is preferred for MAPD plans.

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

B. INSURANCE INFORMATION

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

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration: ☐ Self-administered ☐ Physician's Office ☐ Outpatient Infusion Center Phone: _____ Center Name: _____ ☐ Home Infusion Center Phone: _____ Agency Name: _____ ☐ Administration code(s) (CPT): _____ Address: _____	Dispensing Provider/Pharmacy: ☐ Physician's Office ☐ Retail Pharmacy ☐ Specialty Pharmacy ☐ Other _____ Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____
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E. PRODUCT INFORMATION

Rituxan (rituximab) : 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 All Requests (clinical documentation required for all requests):

Note: Rituxan is non-preferred for Rheumatoid Arthritis. The preferred product is Renflexis (MA) or Humira (MAPD)

- ☐ Yes ☐ No Has the patient had prior therapy with Rituxan (rituximab) within the last 365 days?
☐ Yes ☐ No Has the patient had a trial, intolerance, or contraindication to Renflexis (infliximab-abda)?
☐ Yes ☐ No Has the patient had a trial, intolerance, or contraindication to Humira (adalimumab)?
Please explain if there are any other medical reason(s) that the patient cannot use Renflexis (infliximab-abda).

Please explain if there are any other medical reason(s) that the patient cannot use Humira (adalimumab).

- ☐ 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 foliaceus ☐ bullous pemphigoid ☐ cicatricial pemphigoid
☐ epidermolysis bullosa acquisita ☐ paraneoplastic pemphigus ☐ None of the above

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

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)?

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?

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

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

Please indicate length of treatment: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

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

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

Please indicate length of treatment: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

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 multiple sclerosis only:

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

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

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?

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.