



# 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 Medicare Advantage Part B:

FAX: 1-844-268-7263

PHONE: 1-866-503-0857

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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Group #: _____		If yes, provide ID#: _____ Carrier Name: _____			
Insured: _____		Insured: _____			
C. PRESCRIBER INFORMATION					
First Name: _____		Last Name: _____ (Check one): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.			
Address: _____			City: _____	State: _____	ZIP: _____
Phone: _____	Fax: _____	St Lic #: _____	NPI #: _____	DEA #: _____	UPIN: _____
Office Contact Name: _____				Phone: _____	
D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION					
<b>Place of Administration:</b>			<b>Dispensing Provider/Pharmacy:</b>		
<input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office			<input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy		
<input type="checkbox"/> Outpatient Infusion Center Phone: _____			<input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other _____		
Center Name: _____			Name: _____		
<input type="checkbox"/> Home Infusion Center Phone: _____			Address: _____		
Agency Name: _____			Phone: _____ Fax: _____		
<input type="checkbox"/> Administration code(s) (CPT): _____			TIN: _____ PIN: _____		
Address: _____					
E. PRODUCT INFORMATION					
Request is for: <input type="checkbox"/> Rituxan (rituximab) <input type="checkbox"/> Ruxience (rituximab-pvvr) <input type="checkbox"/> 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: _____			<input type="checkbox"/> 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):					
<b>Note: Rituxan is non-preferred for Rheumatoid Arthritis. The preferred product is Renflexis (MA) or Humira (MAPD)</b>					
<input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had prior therapy with Rituxan (rituximab) within the last 365 days?					
<input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had a trial, intolerance, or contraindication to Renflexis (infliximab-abda)?					
<input type="checkbox"/> Yes <input type="checkbox"/> 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).					
_____					
<input type="checkbox"/> Yes <input type="checkbox"/> No Will Rituxan (rituximab) be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, infliximab)?					
Acute lymphoid leukemia					
<input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have a documented diagnosis of Philadelphia chromosome-negative acute lymphoid leukemia (ALL)?					
<input type="checkbox"/> Yes <input type="checkbox"/> No Is Rituxan (rituximab) being used as induction/consolidation therapy?					
Autoimmune hemolytic anemia					
<input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Wegener granulomatosis <input type="checkbox"/> Churg-Strauss syndrome					
<input type="checkbox"/> microscopic polyangiitis <input type="checkbox"/> pauci-immune glomerulonephritis					
<input type="checkbox"/> Yes <input type="checkbox"/> No Will Rituxan (rituximab) be given in conjunction with glucocorticoids?					
Autoimmune blistering diseases, corticosteroid-refractory					
<input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have a documented diagnosis of corticosteroid-refractory autoimmune blistering disease?					
Please select which applies to the patient: <input type="checkbox"/> pemphigus vulgaris <input type="checkbox"/> pemphigus foliaceus <input type="checkbox"/> bullous pemphigoid <input type="checkbox"/> cicatricial pemphigoid					
<input type="checkbox"/> epidermolysis bullosa acquisita <input type="checkbox"/> paraneoplastic pemphigus <input type="checkbox"/> None of the above					

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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.

**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-myooclonus-ataxia (opsoclonus myoclonus syndrome)**

Yes  No Does the patient have a documented diagnosis of opsoclonus-myooclonus-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.