



MEDICARE FORM

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

Page 1 of 5

(All fields must be completed and legible for precertification review.)

For Medicare Advantage Part B:
For other lines of business:
Please use commercial form.

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

Would you like to use electronic prior authorization? Consider using **Availity**, our electronic prior authorization portal. Learn more about **Availity** from the links in the table below.

For phone or fax requests, refer to the table below for routing information. To determine which box to use, refer to the patient's Aetna ID card. State specific special needs and Medicare-Medicaid Plans may be designated on the front of the ID card or in the website URL on the back of the card. If you don't see your specific plan listed, call the number on the back of the member's ID card to confirm routing information.

For **Aetna Medicare Advantage** and **Allina Health Aetna Medicare** members send request to:

Phone: [1-866-503-0857](tel:1-866-503-0857) (TTY: [711](tel:1-866-503-0857))

Fax: [1-844-268-7263](tel:1-844-268-7263)

Availity: <https://www.aetna.com/health-care-professionals/resource-center/availability.html>

For Aetna Medicare Advantage **Virginia Dual Eligible Special Needs Plans** (HMO D-SNP) send request to:

Phone: [1-855-463-0933](tel:1-855-463-0933)

Fax: [1-833-280-5224](tel:1-833-280-5224)

Availity: <https://www.aetnabetterhealth.com/virginia-hmosnp/providers/portal>

For Aetna Assure Premier Plus Medicare Advantage **New Jersey Dual Eligible Special Needs Plans** (HMO D-SNP) send request to:

Phone: [1-844-362-0934](tel:1-844-362-0934)

Fax: [1-833-322-0034](tel:1-833-322-0034)

Availity: <https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/portal.html>

For Aetna Better Health of **Illinois Premier Medicare Medicaid Plan** (MMP) send request to:

Phone: [1-866-600-2139](tel:1-866-600-2139)

FAX: [1-855-320-8445](tel:1-855-320-8445)

Availity: <https://www.aetnabetterhealth.com/illinois/providers/portal>

For Aetna Better Health of **Ohio Premier Medicare Medicaid Plan** (MMP) send request to:

Phone: [1-855-364-0974](tel:1-855-364-0974)

Fax: [1-855-734-9389](tel:1-855-734-9389)

Availity: <https://www.aetnabetterhealth.com/ohio/providers/portal>

For Aetna Better Health of **Michigan Premier Medicare Medicaid Plan** (MMP) send request to:

Phone: [1-855-676-5772](tel:1-855-676-5772)

Fax: [1-844-241-2495](tel:1-844-241-2495)

Availity: <https://www.aetnabetterhealth.com/michigan/providers/portal.html>



MEDICARE FORM

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

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For Medicare Advantage Part B: For other lines of business: Please use commercial form.

Note: Riabni and Rituxan are non-preferred. The preferred biosimilar 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

Form section A: Patient Information. Fields include First Name, Last Name, DOB, Address, City, State, ZIP, Home Phone, Work Phone, Cell Phone, E-mail, Current Weight, Height, and Allergies.

B. INSURANCE INFORMATION

Form section B: Insurance Information. Fields include Member ID #, Group #, Insured, Does patient have other coverage?, If yes, provide ID#, Carrier Name, and Insured.

C. PRESCRIBER INFORMATION

Form section C: Prescriber Information. Fields include First Name, Last Name, Address, City, State, ZIP, Phone, Fax, St Lic #, NPI #, DEA #, UPIN, Provider Email, Office Contact Name, and Phone.

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Form section D: Dispensing Provider/Administration Information. Divided into Place of Administration and Dispensing Provider/Pharmacy. Includes fields for address, phone, NPI, TIN, and various facility types.

E. PRODUCT INFORMATION

Form section E: Product Information. Fields include Request is for (Riabni, Rituxan, Ruxience, Truxima), Dose, Directions for Use, and HCPCS Code.

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

Form section F: Diagnosis Information. Fields include Primary ICD Code and 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 the preferred biosimilars for most indications. For rheumatoid arthritis, all Rituxan and biosimilar products are non-preferred. Inflectra, Renflexis and Simponi Aria are preferred for MA plans. Enbrel, Humira, Idacio, Rinvoq, Tynne SC and Xeljanz/Xeljanz XR are preferred for MAPD plans.

Form section G: Clinical Information. Includes questions about prior therapy, trial and failure of preferred drug, and adverse reactions to preferred drug.

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

Form section G: Clinical Information. Includes checkboxes for Ruxience and Truxima.

Continued on next page



MEDICARE FORM

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

Page 3 of 5

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**For Medicare Advantage Part B:
For other lines of business:**
Please use commercial form.

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

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.

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

- No Has the patient had a trial and failure of any of the following? (If yes, select all that apply)
 - Inflectra (infliximab-dyyb) Renflexis (infliximab-abda) Simponi Aria (golimumab)
 - When was the member's trial and failure of the preferred drug? _____
 - Please describe the nature of the failure of the preferred drug _____
- No Has the patient had an adverse reaction to any of the following? (If yes, select all that apply)
 - Inflectra (infliximab-dyyb) Renflexis (infliximab-abda) Simponi Aria (golimumab)
 - When was the member's adverse reaction to the preferred drug? _____
 - Please describe the nature of the adverse reaction to the preferred drug _____
- No Has the patient had a trial and failure of any of the following? (If yes, select all that apply)
 - Enbrel (etanercept) Humira (adalimumab) Idacio (adalimumab-aacf) Rinvoq (upadacitinib) Tylene SC (tocilizumab-aazg)
 - Xeljanz/Xeljanz XR (tofacitinib)
 - When was the member's trial and failure of the preferred drug? _____
 - Please describe the nature of the failure of the preferred drug _____
- No Has the patient had a trial and failure of any of the following? (If yes, select all that apply)
 - Enbrel (etanercept) Humira (adalimumab) Idacio (adalimumab-aacf) Rinvoq (upadacitinib) Tylene SC (tocilizumab-aazg)
 - Xeljanz/Xeljanz XR (tofacitinib)
 - When was the member's adverse reaction to the preferred drug? _____
 - Please describe the nature of the adverse reaction to the preferred drug _____

Please explain if there are any contraindications or 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)

- Inflectra (infliximab-dyyb) Renflexis (infliximab-abda) Simponi Aria (golimumab)

Please explain if there are contraindications or 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) Idacio (adalimumab-aacf) Rinvoq (upadacitinib) Tylene SC (tocilizumab-aazg)
- 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 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: _____

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

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-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?

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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

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)?

Waldenström'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.