Riabni™ (rituximab-arrx) Medication Precertification Request

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

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

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:	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: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

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 E-mail:	Office Contact Name:	Phone:			

Specialty *(Check one):* ☐ **Rheumatologist** ☐ **Oncologist** ☐ **Other**: _____

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: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: ☐ Riabni (rituximab-arrx) **Dose:** _____ **Directions for Use:** _____

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):

☐ Yes ☐ No Has the patient failed treatment with Truxima due to a documented intolerable adverse event (e.g., rash, nausea, vomiting)?
→ ☐ Yes ☐ No Was the adverse event unexpected and not attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the brand and biosimilar medication)?

Non-Oncology

☐ **As part of a non-myeloablative conditioning regimen for allogeneic transplant**
☐ **Autoimmune hemolytic anemia**
☐ **Autoimmune blistering diseases**
Please select which applies to the patient: ☐ pemphigus vulgaris ☐ pemphigus foliaceus ☐ bullous pemphigoid ☐ cicatricial pemphigoid ☐ epidermolysis bullosa acquisita ☐ paraneoplastic pemphigus ☐ none of the above
☐ **Chronic graft versus host disease**
☐ **Cryoglobulinemia**
☐ Yes ☐ No Have corticosteroids and other immunosuppressive agents been ineffective?
☐ **Churg-Strauss syndrome**
☐ **Granulomatosis with polyangiitis (GPA) (Wegener's granulomatosis)**
☐ **Immune Checkpoint Inhibitor-related toxicities**
☐ **Immune or idiopathic thrombocytopenic purpura (ITP), refractory**
☐ **Microscopic polyangiitis (MPA)**
☐ **Multiple sclerosis (MS)**
☐ Yes ☐ No Has the patient been diagnosed with relapsing-remitting multiple sclerosis (RRMS)?
☐ Yes ☐ No Is the patient taking the requested medication with any other medication used for the treatment of multiple sclerosis other than Ampyra?
☐ **Myasthenia gravis, refractory**

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

☐ **Neuromyelitis optica (i.e., neuromyelitis optica spectrum disorder (NMOSD), Devic disease)**
- ☐ Yes ☐ No Will the requested drug be used concomitantly with another biologic for the treatment of neuromyelitis optica spectrum disorder (NMOSD)?

☐ **Opsoclonus-myoclonus ataxia**
- ☐ Yes ☐ No Is the requested drug being used for associated opsoclonus-myoclonus ataxia associated with neuroblastoma?
- ☐ Yes ☐ No Is the patient refractory to steroids and chemotherapy?

☐ **Pauci-immune glomerulonephritis**

☐ **Prevention of Epstein-Barr virus (EBV) related post-transplant lymphoproliferative disorder (PTLD)**

☐ **Rheumatoid arthritis (RA)**
- ☐ Yes ☐ No Has the patient been diagnosed with moderately to severely active rheumatoid arthritis (RA)?
- ☐ Yes ☐ No Has the patient received a biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) that is indicated for moderately to severely active rheumatoid arthritis?
  - → ☐ Yes ☐ No Has the patient received two full doses of the requested medication, with the most recent dose being 6 months before this request?
    - → ☐ Yes ☐ No Has the patient been tested for the rheumatoid factor (RF) biomarker?
      Please indicate the test result: ☐ positive ☐ negative ☐ not completed
      ☐ Yes ☐ No Has the patient been tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker?
      Please indicate the test result: ☐ positive ☐ negative ☐ not completed
      ☐ Yes ☐ No Has the patient been tested for the C-reactive protein (CRP) biomarker?
      Please indicate the test result: ☐ positive ☐ negative ☐ not completed
      ☐ Yes ☐ No Has the patient been tested for the erythrocyte sedimentation rate (ESR) biomarker?
      Please indicate the test result: ☐ positive ☐ negative ☐ not completed
      ☐ Yes ☐ No Has the patient experienced an inadequate response after at least 3 months of treatment with the methotrexate dose greater than or equal to 15 mg per week?
- ☐ Yes ☐ No Has the patient experienced an inadequate response with another conventional DMARD (e.g., hydroxychloroquine, leflunomide, sulfasalazine)?
- ☐ Yes ☐ No Is the requested drug being prescribed in combination with methotrexate or leflunomide?
  - → ☐ Yes ☐ No Has the patient experienced intolerance to methotrexate or leflunomide?
    - → ☐ Yes ☐ No Does the patient have a contraindication to methotrexate or leflunomide?
      - → Please indicate the contraindication:
        ☐ History of intolerance or adverse event ☐ Renal impairment ☐ Hypersensitivity
        ☐ Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)
        ☐ Breastfeeding ☐ Elevated liver transaminases ☐ Myelodysplasia
        ☐ Interstitial pneumonitis or clinically significant pulmonary fibrosis
        ☐ Pregnancy or currently planning pregnancy ☐ Significant drug interaction
        ☐ Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease
        ☐ Other: _____
- ☐ Yes ☐ No Will the requested drug be used with another biologic for the treatment of rheumatoid arthritis?
- ☐ Yes ☐ No Is the planned date of administration at least 16 weeks after the date of the last dose received?

☐ **Sjögren's syndrome**
- ☐ Yes ☐ No Have corticosteroids and other immunosuppressive agents been ineffective?

☐ **Solid organ transplant and prevention of antibody mediated rejection in solid organ transplant**
- ☐ Yes ☐ No Is the requested drug being used for the treatment and prevention of antibody mediated rejection in solid organ transplant?

☐ **Systemic Lupus Erythematosus (SLE)**
- ☐ Yes ☐ No Is the disease refractory to immunosuppressive therapy?

☐ **Thrombotic thrombocytopenic purpura (TTP)**

Oncology:

☐ Yes ☐ No Does the patient have CD20 positive disease that was confirmed by testing or analysis?
→ **Action required: If 'Yes', attach results of testing or analysis confirming CD20 protein on the surface of the B-cell**.

Please indicate the patient's documented diagnosis:
☐ Acquired immunodeficiency syndrome (AIDS)-related B-cell lymphoma
☐ B-cell acute lymphoblastic leukemia (ALL)
☐ B-cell lymphoblastic lymphoma
☐ Burkitt lymphoma
☐ Castleman's disease
☐ Central nervous system (CNS) cancers with leptomeningeal metastases from lymphomas
☐ Central nervous system (CNS) cancers with primary central nervous system (CNS) lymphoma

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- ☐ Chronic lymphocytic leukemia (CLL)
- ☐ Diffuse large B-cell lymphoma (DLBCL)
- ☐ Follicular lymphoma
- ☐ Hairy cell leukemia
- ☐ High-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 (double/triple hit lymphoma)
- ☐ High-grade B-cell lymphoma, not otherwise specified
- ☐ Histological transformation of indolent lymphomas to diffuse large B-cell lymphoma
- ☐ Hodgkin's lymphoma, nodular lymphocyte-predominant
- ☐ Mantle cell lymphoma
- ☐ Marginal zone lymphomas (nodal marginal zone lymphoma, gastric mucosa associated lymphoid tissue (MALT) lymphoma, nongastric MALT lymphoma, splenic marginal zone lymphoma)
- ☐ Pediatric Aggressive Mature B-Cell Lymphomas
- ☐ Post-transplant lymphoproliferative disorder (PTLD)
- ☐ Primary cutaneous B-cell lymphoma
- ☐ Rosai-Dorfman disease
- ☐ Small lymphocytic lymphoma (SLL)
- ☐ Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma (LPL)

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

☐ Yes ☐ No Has the patient failed treatment with Truxima due to a documented intolerable adverse event (e.g., rash, nausea, vomiting)?
→ ☐ Yes ☐ No Was the adverse event unexpected and not attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the brand and biosimilar medication)

Rheumatoid Arthritis (RA)

Please indicate the number of total doses the patient has received since starting treatment with the requested medication: _____

☐ Yes ☐ No Will the requested medication be used with another biologic for the treatment of rheumatoid arthritis?

Please indicate the percent of disease activity improvement from baseline in tender joint count, swollen joint count, pain, or disability: _____ %

Multiple sclerosis (MS)

☐ Yes ☐ No Is the patient experiencing disease stability or improvement while receiving the requested medication?

Continuation, oncologic indications

☐ Yes ☐ No Has the patient experienced an unacceptable toxicity from treatment with the requested drug?

Continuation, immune checkpoint inhibitor-related toxicities and all other indications

☐ Yes ☐ No Is the patient experiencing benefit from therapy?

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.