

Reference number(s)
3509-D

This document applies to the following:

Formulary	Applies
Standard Control (SF)	<input type="checkbox"/>
Standard Control – Choice (SCCF)	<input type="checkbox"/>
Preferred Drug Plan Design (PDPD)	<input type="checkbox"/>
Advanced Control Specialty (ACSF)	<input type="checkbox"/>
Advanced Control Specialty – Choice (ACSCF)	<input type="checkbox"/>
Managed Medicaid Template (MMT)	<input type="checkbox"/>
Marketplace (MF)	<input type="checkbox"/>
Aetna Small Group Affordable Care Act (SG ACA)	<input type="checkbox"/>
Aetna Health Exchange (AHE)	<input type="checkbox"/>
Aetna Individual Lives (IVL)	<input type="checkbox"/>
Value (VF)	<input type="checkbox"/>

Formulary	Applies
New to Market (NTM)	<input type="checkbox"/>
Standard Formulary Chart (SFC)	<input type="checkbox"/>
Basic Control Chart Preferred Drug Plan Design (BCC PDPD)	<input type="checkbox"/>
Advanced Control Specialty Formulary Chart (ACSFC)	<input type="checkbox"/>
Value Formulary Chart (VFC)	<input type="checkbox"/>
Medical Benefit	<input checked="" type="checkbox"/>
Medical Benefit: Advanced Biosimilars First	<input type="checkbox"/>
Medical Benefit: Managed Medicaid (MMMB)	<input type="checkbox"/>
Medicare Part B	<input type="checkbox"/>
Medicare Part B: Advanced Biosimilars First	<input type="checkbox"/>

Exceptions Criteria Rituximab Products

This document informs prescribers of preferred products and provides an exception process for targeted products through prior authorization.

These criteria were developed to align with the following: Medical Benefit.

Plan Design Summary

This program applies to the rituximab products specified in this document. Coverage for targeted products is provided based on clinical circumstances that would exclude the use of the preferred product and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made. This program applies to all members requesting treatment with a targeted product.

Each referral is reviewed based on all utilization management (UM) programs implemented for the client.

Table. Rituximab Products

Medications considered formulary or preferred on your plan may still require a clinical prior authorization review.

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	Products
Preferred	<ul style="list-style-type: none"> • Truxima (rituximab-abbs)
Targeted	<ul style="list-style-type: none"> • Riabni (rituximab-arrx) • Rituxan (rituximab) • Rituxan Hycela (rituximab and hyaluronidase human) • Ruxience (rituximab-pvvr)

Exception Criteria

Coverage for a targeted product is provided when the member has had a documented intolerable adverse event to the preferred product. The adverse event must not be an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the reference product and biosimilar products).

References

1. Riabni [package insert]. Thousand Oaks, CA: Amgen, Inc.; February 2023.
2. Rituxan [package insert]. South San Francisco, CA: Genentech, Inc.; December 2021.
3. Rituxan Hycela [package insert]. South San Francisco, CA: Genentech, Inc.; June 2021.
4. Ruxience [package insert]. New York, NY: Pfizer; October 2023.
5. Truxima [package insert]. North Wales, PA: Teva Pharmaceuticals USA, Inc; February 2022.