Rituxan, Ruxience, Truxima, Riabni

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756** to initiate the review process. If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____**Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Drug Information:

*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un

*Directions(sig)*_____ *Route of administration*_____

*Dosing frequency*_____

Send completed form to: Priority Partners Fax: 1-866-212-4756

 JHHC SOC Rituxan, Ruxience, Truxima, Riabni SGM – 10/2021.

Site of Service Questions:

A. Indicate the site of service requested:
- ❑ On Campus Outpatient Hospital
- ❑ Off Campus Outpatient Hospital
- ❑ Home based setting, *skip to Criteria Questions*
- ❑ Community office, *skip to Criteria Questions*
- ❑ Ambulatory infusion site, *skip to Criteria Questions*

B. Is the patient less than 18 years of age?
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No

C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, other pre- medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

D. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

F. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

G. Has the patient's home been deemed not eligible or appropriate for home infusion services by a home infusion provider? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

H. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?
ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation. ❑ Yes ❑ No

Clinical Criteria Questions:

1. What is the prescribed product? ❑ Rituxan ❑ Ruxience ❑ Truxima ❑ Riabni

2. What is the diagnosis?

Non-Oncology

- ❑ Moderately to severely active rheumatoid arthritis
- ❑ Relapsing-remitting multiple sclerosis (RRMS)
- ❑ Granulomatosis with polyangiitis (GPA) (Wegener's granulomatosis)
- ❑ Microscopic polyangiitis (MPA)
- ❑ Churg-Strauss syndrome
- ❑ Pauci-imune glomerulonephritis
- ❑ Sjögren's syndrome
- ❑ Immune or idiopathic thrombocytopenic purpura (ITP), refractory
- ❑ Autoimmune hemolytic anemia
- ❑ Thrombotic thrombocytopenic purpura (TTP)
- ❑ Myasthenia gravis, refractory
- ❑ Chronic graft versus host disease
- ❑ Prevention of Epstein-Barr virus (EBV) related post-transplant lymphoproliferative disorder (PTLD)
- ❑ Neuromyelitis optica (i.e., neuromyelitis optica spectrum disorder; NMOSD, Devic disease)
- ❑ Autoimmune blistering disease (e.g., pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, cicatricial pemphigoid, epidermolysis bullosa acquisita and paraneoplastic pemphigus)
- ❑ Cryoglobulinemia
- ❑ Solid organ transplant and prevention of antibody mediated rejection in solid organ transplant
- ❑ Opsoclonus-myoclonus ataxia
- ❑ Systemic lupus erythematosus
- ❑ Immune Checkpoint Inhibitor-related toxicities

Oncology

- ❑ Diffuse large B-cell lymphoma (DLBCL), CD20 positive
- ❑ High-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 (double/triple hit lymphoma), CD20 positive
- ❑ High-grade B-cell lymphoma, not otherwise specified, CD20 positive
- ❑ Follicular lymphoma, CD20 positive
- ❑ Mantle cell lymphoma, CD20 positive
- ❑ Marginal zone lymphomas (nodal marginal zone lymphoma, gastric mucosa associated lymphoid tissue [MALT] lymphoma, Nongastric MALT lymphoma, splenic marginal zone lymphoma), CD20 positive
- ❑ Burkitt lymphoma, CD20 positive
- ❑ Castleman's disease, CD20 positive
- ❑ Acquired immunodeficiency syndrome (AIDS-)-related B-cell lymphoma, CD20 positive
- ❑ Post-transplant lymphoproliferative disorder (PTLD), CD20 positive
- ❑ B-cell lymphoblastic lymphoma, CD20 positive
- ❑ Histological transformation from follicular lymphoma to diffuse large B-cell lymphoma, CD20 positive
- ❑ Histological transformation from nodal marginal zone lymphoma to diffuse large B-cell lymphoma, CD20 positive
- ❑ Primary cutaneous B-cell lymphoma, CD20 positive
- ❑ Hairy cell leukemia, CD20 positive
- ❑ Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma (LPL), CD20 positive
- ❑ Hodgkin's lymphoma, nodular lymphocyte-predominant, CD20 positive
- ❑ Primary central nervous system (CNS) lymphoma, CD20 positive
- ❑ Leptomeningeal metastases from lymphomas, CD20 positive q B-cell acute lymphoblastic leukemia (ALL), CD20 positive
- ❑ Chronic lymphocytic leukemia (CLL), CD20 positive
- ❑ Small lymphocytic lymphoma (SLL), CD20 positive

❑ Pediatric aggressive mature B-cell lymphomas, CD20 positive
❑ Rosai-Dorfman disease, CD20 positive
❑ Other _____

3. What is the ICD-10 code? _____
If diagnosis is RA, MS or any oncologic indications, skip to diagnosis section.

4. Is this a request for continuation of therapy with the requested drug?
❑ Yes ❑ No *If No, skip to diagnosis section.*

5. Is the patient experiencing benefit from therapy? ❑ Yes ❑ No

Complete the following section(s) based on the patient's diagnosis, if applicable.

Section A: Rheumatoid Arthritis

6. Has the patient previously received a biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) that is indicated for moderately to severely active rheumatoid arthritis? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and skip to #13.*** ❑ Yes ❑ No

7. Has the patient received at least two full doses of the requested medication, with the most recent dose being within 6 months before this request? *If Yes, skip to #13* ❑ Yes ❑ No

8. Does the patient meet BOTH of the following: a) the patient was tested for the rheumatoid factor (RF) biomarker AND b) the RF biomarker test was positive? ***ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing and skip to #12.*** ❑ Yes ❑ No

9. Does the patient meet BOTH of the following: a) the patient was tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker AND b) the anti-CCP biomarker test was positive? ***ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing and skip to #12.***
❑ Yes ❑ No

10. Has the patient been tested for ANY of the following? ***ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing.***
❑ Rheumatoid factor (RF) biomarker ❑ Anti-cyclic citrullinated peptide (anti-CCP) biomarker
❑ None of the above

11. Has the patient been tested for the C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR) biomarker(s)? ***ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing.*** *Indicate ALL that apply.*
❑ Positive for CRP ❑ Positive for ESR ❑ Test for CRP was not completed
❑ Negative for CRP ❑ Negative for ESR ❑ Test for ESR was not completed

12. Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate at a dose greater than or equal to 20 mg per week? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.***
❑ Yes ❑ No

13. Is the requested drug being prescribed in combination with methotrexate? *If Yes, skip to #17* ❑ Yes ❑ No

14. Has the patient experienced an intolerance to methotrexate? *If Yes, skip to #16* ❑ Yes ❑ No

15. Does the patient have a contraindication to methotrexate? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No
If Yes, indicate contraindication: _____

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16. Has the patient experienced an inadequate response with another conventional DMARD (e.g., hydroxychloroquine, leflunomide, sulfasalazine)? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.*** ❑ Yes ❑ No

17. Will the requested drug be used with another biologic for the treatment of rheumatoid arthritis? ❑ Yes ❑ No

18. Is the planned date of administration at least 16 weeks after the date of the last dose received?
❑ Yes ❑ No ❑ Not applicable - Patient has not received any previous dose

19. Is this request for continuation of therapy? ❑ Yes ❑ No *If No, no further questions.*

20. How many doses in total has the patient received since starting treatment with the requested medication?
_____ doses *If one dose, no further questions.*

21. Has the patient achieved or maintained positive clinical response since starting treatment with the requested medication? ❑ Yes ❑ No

22. What is the percent of disease activity improvement from baseline in tender joint count, swollen joint count, pain, or disability? ***ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response.*** _____%

Section B: Multiple Sclerosis

23. Is the patient taking the requested medication with any other medication used for the treatment of multiple sclerosis other than Ampyra? ❑ Yes ❑ No

24. Is this a request for continuation of therapy? ❑ Yes ❑ No *If No, no further questions.*

25. Is the patient experiencing disease stability or improvement while receiving the requested medication?
❑ Yes ❑ No

Section C: Oncologic Indications

26. Is this a request for continuation of therapy with the requested drug? ❑ Yes ❑ No

27. 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. ❑ Yes ❑ No ❑ Unknown *No further questions*

28. Is there evidence of unacceptable toxicity on the current regimen? ❑ Yes ❑ No

Section D: Systemic Lupus Erythematosus

29. Is the disease refractory to immunosuppressive therapy? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.*** ❑ Yes ❑ No

Section E: Sjogren's Syndrome or Cryoglobulinemia

30. Have corticosteroids and other immunosuppressive agents been ineffective? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.*** ❑ Yes ❑ No

Section F: Neuromyelitis Optica (i.e., Neuromyelitis Optica Spectrum Disorder; NMOSD, Devic Sisease)

31. Has at least one other immunotherapy agent been ineffective? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.*** ❑ Yes ❑ No

32. Will the patient receive the requested drug concomitantly with other biologics for the treatment of neuromyelitis optica spectrum disorder (NMOSD)? ❑ Yes ❑ No

Section G: Autoimmune Blistering Disease (e.g., Pemphigus Vulgaris, Pemphigus Foliaceus, Bullous Pemphigoid, Cicatricial Pemphigoid, Epidermolysis Bullosa Acquisita and Paraneoplastic Pemphigus)

33. Is the disease corticosteroid refractory? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.***
    ❑ Yes ❑ No

Section H: Solid Organ Transplant

34. Is the requested drug being used for the prevention of antibody mediated rejection in solid organ transplant?
    ❑ Yes ❑ No

Section I: Opsoclonus-Myoclonus-Ataxia

35. Is the requested drug being used for opsoclonus-myoclonus ataxia associated with neuroblastoma?
    ❑ Yes ❑ No

36. Is the patient refractory to steroids and chemotherapy? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.*** ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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