



Rituxan, Ruxience, Truxima, Riabni

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518**. For inquiries or questions related to the patient's eligibility, drug copy or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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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

Please indicate the place of service for the requested drug:

- Ambulatory Surgical Home Off Campus Outpatient Hospital
 On Campus Outpatient Hospital Office Pharmacy

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

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CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062

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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-immune 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 lymphoma (nodal, splenic or gastric/non-gastric mucosa-associated lymphoid tissue [MALT] 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
- B-cell acute lymphoblastic leukemia (ALL), CD20 positive
- Chronic lymphocytic leukemia (CLL), CD20 positive
- Small lymphocytic lymphoma (SLL), CD20 positive
- Other ____

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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: _____
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

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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 Disease)

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

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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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