aetna™

MEDICARE FORM

Rituxan® (rituximab) Medication Precertification Request

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

For Medicare Advantage Part B:
FAX: 1-844-268-7263
PHONE: 1-866-503-0857

For other lines of business:
Please use other form.

Note: Rituxan is non-preferred. Renflexis is the preferred product for MA plans and Humira is preferred for MAPD plans.

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:	Allergies:	E-mail:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

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:
Office Contact Name:				Phone:	

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

E. PRODUCT INFORMATION

Rituxan (rituximab) : Dose: _____ **Directions for Use:** _____ **HCPCS Code:** _____

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):

Note: Rituxan is non-preferred. The preferred product is Renflexis (MA) or Humira (MAPD)

☐ Yes ☐ No Has the patient had prior therapy with Rituxan (rituximab) within the last 365 days?
☐ Yes ☐ No Has the patient had a trial, intolerance, or contraindication to Renflexis (infliximab-abda)?
☐ Yes ☐ No Has the patient had a trial, intolerance, or contraindication to Humira (adalimumab)?

Please explain if there are any other medical reason(s) that the patient cannot use Renflexis (infliximab-abda).

_____

Please explain if there are any other medical reason(s) that the patient cannot use Humira (adalimumab).

_____

☐ 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 folliaceus ☐ bullous pemphigoid ☐ cicatricial pemphigoid ☐ epidermolysis bullosa acquisita ☐ paraneoplastic pemphigus ☐ None of the above

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

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: _____

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: __/__/__ - __/__/__
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

Please indicate length of treatment: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

☐ Yes ☐ No Was treatment with another conventional DMARD ineffective?

→ Please select: ☐ azathioprine ☐ cyclosporine ☐ hydroxychloroquine ☐ leflunomide ☐ sulfasalazine

Please indicate length of treatment: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

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)?

Waldenstrom'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 multiple sclerosis only:

☐ Yes ☐ No Is there clinical documentation supporting disease stability?

☐ Yes ☐ No Is there clinical documentation supporting disease improvement?

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?

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.