MEDICARE FORM

Riabni® (rituximab-arrx), Rituxan® (rituximab), Ruxience (rituximab-pvvr), Truxima (rituximab-abbs) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

For Medicare Advantage Part B:
For other lines of business:
Please use commercial form.

Note: Riabni and Rituxan are non-preferred. The preferred biosimilar products are Ruxience and Truxima. For rheumatoid arthritis, all Rituxan and biosimilar products are non-preferred.

Would you like to use electronic prior authorization? Consider using **Availity**, our electronic prior authorization portal. Learn more about **Availity** from the links in the table below.

For phone or fax requests, refer to the table below for routing information. To determine which box to use, refer to the patient's Aetna ID card. State specific special needs and Medicare-Medicaid Plans may be designated on the front of the ID card or in the website URL on the back of the card. If you don't see your specific plan listed, call the number on the back of the member's ID card to confirm routing information.

For Aetna Medicare Advantage and **Allina Health Aetna Medicare Members** send request to: **Phone:** 1-866-503-0857 **(TTY: 711)** **Fax:** 1-844-268-7263 **Availity:** https://www.aetna.com/health-care-professionals/resource-center/availity.html
For Aetna Medicare FIDE (HMO-DSNP) **Virginia Dual Eligible Special Needs Plans** send request to: **Phone:** 1-855-463-0933 **Fax:** 1-833-280-5224 **Availity:** https://www.aetnabetterhealth.com/virginia-hmosnp/providers/portal
For Aetna Medicare FIDE (HMO-DSNP) **New Jersey Dual Eligible Special Needs Plans** send request to: **Phone:** 1-844-362-0934 **Fax:** 1-833-322-0034 **Availity:** https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/portal.html
For Aetna Medicare FIDE (HMO D-SNP) **Illinois Dual Eligible Special Needs Plans** send request to: **Phone:** 1-866-600-2139 **FAX:** 1-855-320-8445 **Availity:** https://www.aetnabetterhealth.com/illinois/providers/portal
For Aetna Medicare HIDE (HMO D-SNP) **Michigan Dual Eligible Special Needs Plans** send request to: **Phone:** 1-855-676-5772 **Fax:** 1-844-241-2495 **Availity:** https://www.aetnabetterhealth.com/michigan/providers/portal.html

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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:			DOB:
Address:		City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	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: _____

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 Email:		Office Contact Name:		Phone:	

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office ☐ Home
☐ Outpatient Infusion Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

Dispensing Provider/Pharmacy:
☐ *Outpatient Dialysis Center* ☐ Physician's Office
☐ Retail Pharmacy ☐ Specialty Pharmacy
☐ Mail Order ☐ Other: _____
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

E. PRODUCT INFORMATION

Request is for: ☐ **Riabni (rituximab-arrx)** ☐ **Rituxan (rituximab)** ☐ **Ruxience (rituximab-pvvr)** ☐ **Truxima (rituximab-abbs)**
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 Initiation Requests (clinical documentation required for all requests):

Note: Riabni and Rituxan are non-preferred. Ruxience and Truxima are the preferred biosimilars for most indications.
For rheumatoid arthritis, all Rituxan and biosimilar products are non-preferred. Inflectra, Renflexis and Simponi Aria are preferred for MA plans.
Enbrel, Hadlima, Rinvoq, Tyenne SC and Xeljanz/Xeljanz XR are preferred for MAPD plans.

☐ Yes ☐ No Has the patient received a dose of the requested product through insurance in the last 365 days?
This does not include samples or doses administered without prior authorization.

☐ No Has the patient had an intolerable adverse event to both of the following rituximab biosimilars? (If yes, select all that apply)
Medical records (e.g., chart notes) documenting an intolerable adverse event to both preferred products must be available upon request.
☐ Ruxience (rituximab-pvvr) ☐ Truxima (rituximab-abbs)
→ When was the member's intolerable adverse event to the preferred drugs? _____
→ Please describe the nature of the intolerable adverse event to the preferred drugs _____
Was the adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information?
_____
_____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

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

For Initiation Requests *continued* (clinical documentation required for all requests):

☐ No Has the patient had a documented inadequate response to two or more of the following? (If yes, select all that apply)
Medical records (e.g., chart notes) documenting an inadequate response to a trial of two or more preferred products must be available upon request.
☐ Inflectra (infliximab-dyyb) ☐ Renflexis (infliximab-abda) ☐ Simponi Aria (golimumab)
→ When was the member's inadequate response to the preferred drugs? _____
→ Please describe the nature of the inadequate response to the preferred drugs _____

☐ No Has the patient had a documented intolerable adverse event to two or more of the following? (If yes, select all that apply)
Medical records (e.g., chart notes) documenting an intolerable adverse event to two or more preferred products must be available upon request.
☐ Inflectra (infliximab-dyyb) ☐ Renflexis (infliximab-abda) ☐ Simponi Aria (golimumab)
→ When was the member's intolerable adverse event to the preferred drugs? _____
→ Please describe the nature of the intolerable adverse event to the preferred drugs _____

☐ No Has the patient had a documented inadequate response to two or more of the following? (If yes, select all that apply)
Medical records (e.g., chart notes) documenting an inadequate response to a trial of two or more preferred products must be available upon request.
☐ Enbrel (etanercept) ☐ Hadlima (adalimumab-bwwd) ☐ Rinvoq (upadacitinib)
☐ Tyenne SC (tocilizumab-aazg) ☐ Xeljanz/Xeljanz XR (tofacitinib)
→ When was the member's inadequate response of the preferred drugs? _____
→ Please describe the nature of the inadequate response of the preferred drugs _____

☐ No Has the patient had a documented intolerable adverse event to two or more of the following? (If yes, select all that apply)
Medical records (e.g., chart notes) documenting an intolerable adverse event to two or more preferred products must be available upon request.
☐ Enbrel (etanercept) ☐ Hadlima (adalimumab-bwwd) ☐ Rinvoq (upadacitinib) ☐ Tyenne SC (tocilizumab-aazg)
☐ Xeljanz/Xeljanz XR (tofacitinib)
→ When was the member's intolerable adverse event to the preferred drugs? _____
→ Please describe the nature of the intolerable adverse event to the preferred drugs _____

Please explain if there are any contraindications or other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis? (select all that apply)
☐ Inflectra (infliximab-dyyb) ☐ Renflexis (infliximab-abda) ☐ Simponi Aria (golimumab)

_____

Please explain if there are contraindications or any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis? (select all that apply)
☐ Enbrel (etanercept) ☐ Hadlima (adalimumab-bwwd) ☐ Rinvoq (upadacitinib) ☐ Tyenne SC (tocilizumab-aazg) ☐ Xeljanz/Xeljanz XR (tofacitinib)

_____

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

☐ Yes ☐ No Will rituximab be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, infliximab)?

Acquired hemophilia

☐ Yes ☐ No Does the patient have acquired factor VIII deficiency (acquired hemophilia A)?
☐ Yes ☐ No Will the requested medication be used as first-line therapy?
→ ☐ Yes ☐ No Will the requested medication be used as second-line therapy?
→ ☐ Yes ☐ No Does the patient have refractory hemophilia?
→ ☐ Yes ☐ No Will the requested medication be used in combination with corticosteroids?
→ ☐ Yes ☐ No Does the patient have acquired or refractory hemophilia?

Acquired thrombotic thrombocytopenic purpura

☐ Yes ☐ No Does the patient have severe, refractory, or relapsed disease?
☐ Yes ☐ No Has the patient failed first-line therapy of plasma exchange and corticosteroids?

Allergic purpura

☐ Yes ☐ No Does the patient have a diagnosis of allergic purpura?

Allogeneic transplant conditioning

☐ Yes ☐ No Is the medication being used as part of a non-myeloablative conditioning regimen for allogeneic transplant?

Antibody-mediated rejection (AMR)

☐ Yes ☐ No Will the requested medication be used as second-line treatment?
☐ Yes ☐ No Will the requested medication be used as part of combination therapy for a kidney, lung, or cardiac transplant patient?
☐ Yes ☐ No Will the requested medication be used as part of desensitization protocols in a highly sensitized patient awaiting a donor transplant?

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

Anti-myelin associated glycoprotein (anti-MAG) polyneuropathy

☐ Yes ☐ No Does the patient have a diagnosis Anti-myelin associated glycoprotein (anti-MAG) polyneuropathy?

Anti-neutrophil cytoplasmic antibody-associated (ANCA-associated) vasculitides

Please indicate which of the following applies to the patient:

☐ Granulomatosis with polyangiitis (GPA) (Wegener's granulomatosis) ☐ Churg-Strauss syndrome
☐ microscopic polyangiitis (microscopic polyarteritis) (MPA) ☐ pauci-immune glomerulonephritis

☐ Yes ☐ No Will rituximab be given in conjunction with glucocorticoids/corticosteroids??

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

Autoimmune encephalitis

☐ Yes ☐ No Has the member undergone a bone marrow transplant?

Autoimmune hemolytic anemia (AIHA)

☐ Yes ☐ No Will the requested medication be used as first-line therapy for symptomatic, severe cold autoimmune hemolytic anemia (AIHA)?
☐ Yes ☐ No Is the disease refractory to conventional treatment (e.g., corticosteroid treatment and splenectomy)?
☐ Yes ☐ No Will the requested medication be used as second-line therapy for refractory, warm autoimmune hemolytic anemia (AIHA) after failed first-line treatment?

Autologous stem cell rescue

☐ Yes ☐ No Will the requested drug be used as second-line or salvage therapy for progressive or relapsed disease with or without radiation therapy?

Chronic graft versus host disease

☐ Yes ☐ No Will the requested medication be used as first-line therapy?
☐ Yes ☐ No Will the requested drug be used as third-line therapy or greater?

Chronic inflammatory demyelinating polyneuropathy (CIDP)

☐ Yes ☐ No Has the patient failed intravenous immune globulin (IVIG), glucocorticoids, and plasma exchange?

Cryoglobulinemia and cryoglobulinemia-induced renal disease

☐ Yes ☐ No Does the patient have a documented diagnosis of Cryoglobulinemia or cryoglobulinemia-induced renal disease?

Evans syndrome

☐ Yes ☐ No Will the requested medication be used as second-line therapy after failing first-line treatment?

Heart and solid organ transplant

☐ Yes ☐ No Is there a documentation that 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

Hematopoietic stem cell transplant

☐ Yes ☐ No Will the requested medication be used as part of combination treatment for preparative regimens and post-transplantation maintenance?

Immune checkpoint inhibitor-related toxicities

Please identify which immune checkpoint inhibitor caused the toxicity: ☐ Bavencio (avelumab) ☐ Imfinzi (durvalumab) ☐ Imjudo (tremelimumab)
☐ Keytruda (pembrolizumab) ☐ Libtayo (cemiplimab) ☐ Opdivo (nivolumab) ☐ Tecentriq (atezolizumab) ☐ Yervoy (ipilimumab)
☐ Other: _____

Immune-mediated myopathies/Idiopathic inflammatory myopathy

Please select which applies to the patient: ☐ Dermatomyositis (DM) ☐ Polymyositis (PM) ☐ Antisynthetase syndrome
☐ Immune-mediated necrotizing myopathy (IMNM) ☐ Inclusion body myositis (IBM) ☐ Nonspecific myositis
☐ Yes ☐ No Does the disease have extra muscular involvement (e.g., the condition affects the lungs)?
☐ Yes ☐ No Does the patient have refractory disease?
☐ Yes ☐ No Has the patient failed all first-line therapies?

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)

☐ Yes ☐ No Has the patient had a documented lack of response to at least one first-line therapy (e.g., oral corticosteroids, IVIG, or anti-D immunoglobulin)?

→ Which of the following documented risks for bleeding does the patient have? ☐ Severe ITP (bleeding symptoms)
☐ Risk factors for bleeding are present ☐ In preparation for procedures of surgery with risk for bleeding
☐ Professional or lifestyle risk of trauma ☐ Other _____
☐ Yes ☐ No Does the patient have persistent or chronic disease (greater than six months)?

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

Immunoglobulin G4-related disease (IgG4-RD)

☐ Yes ☐ No Will the requested medication be used as second-line therapy?
☐ Yes ☐ No Does the patient have refractory or relapsed disease?
→ ☐ Yes ☐ No Has the patient failed all first-line therapies (e.g., glucocorticoids, immunosuppressants)?
→ ☐ Yes ☐ No Does the patient have an absolute contraindication to corticosteroid use?

Immunotherapy-related encephalitis

☐ Yes ☐ No Is the patient positive for autoimmune encephalopathy antibodies?
→ ☐ Yes ☐ No Did the patient have limited or no improvement with first-line therapy?

Immunotherapy-related toxicity

Which agent caused the toxicity: ☐ Immune checkpoint inhibitor ☐ CAR T-cell therapy
Please identify which immune checkpoint inhibitor caused the toxicity: ☐ Bavencio (avelumab) ☐ Imfinzi (durvalumab) ☐ Imjudo (tremelimumab)
☐ Keytruda (pembrolizumab) ☐ Libtayo (cemiplimab) ☐ Opdivo (nivolumab) ☐ Tecentriq (atezolizumab) ☐ Yervoy (ipilimumab)
☐ Other: _____
Please identify which CAR T-cell therapy caused the toxicity: ☐ Abecma (idecabtagene vicleucel) ☐ Breyanzi (lisocabtagene maraleucel)
☐ Carvykti (ciltacabtagene autoleucel) ☐ Kymriah (tisagenlecleucel) ☐ Tecartus (brexucabtagene autoleucel) ☐ Yescarta (axicabtagene ciloleucel)
☐ Other: _____

Kidney transplant, rejection prophylaxis

☐ Yes ☐ No Is 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?

Lung disease with systemic sclerosis

☐ Yes ☐ No Is the disease refractory to standard therapy (e.g., cyclophosphamide, mycophenolate)?

Lupus nephritis

☐ Yes ☐ No Has the patient experienced worsening disease while on at least 3 months of therapy with glucocorticoids plus cyclophosphamide or mycophenolate mofetil?
→ ☐ Yes ☐ No Has the patient failed at least 6 months of conventional therapy with cyclophosphamide or mycophenolate mofetil?

Membranous nephropathy

☐ Yes ☐ No Is the patient at moderate to high risk for disease progression?
☐ Yes ☐ No Does the patient have refractory or resistant disease?
→ ☐ Yes ☐ No Does the patient have proteinuria of at least 5 grams per 24 hours in quantified creatinine clearance of at least 40 ml per minute per 1.73 m2 of the body surface area?
→ ☐ Yes ☐ No Has the patient received an angiotensin-system blockade (ACE-inhibitor or ARB drug) for at least 3 months?
→ ☐ Yes ☐ No Will the dose of the requested medication be 2 infusions, 1000 mg each, administered 14 days apart?

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) ☐ Refractory MS
☐ Yes ☐ No Will the requested drug be used as a second-line option in a patient that failed first-line therapy?
☐ Yes ☐ No Will the requested drug be used as third-line therapy?

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?

Multifocal motor neuropathy

☐ Yes ☐ No Will the requested drug be used as second-line therapy?

Myasthenia gravis

☐ Yes ☐ No Does the patient have muscle-specific tyrosine kinase (MuSK)-positive disease with an unsatisfactory response to initial immunotherapy?
→ Does the patient have acetylcholine receptor antibody positive (AChR-Ab+) disease and failed or did not tolerate other immunosuppressive agents?
☐ Yes ☐ No Is the patient's condition refractory to standard therapy (e.g., corticosteroids, immunosuppressants)?
→ ☐ Yes ☐ No Is there a clinical reason to avoid treatment with standard therapy?

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Minimal change disease (nephrotic syndrome)

☐ Yes ☐ No Does the patient have frequently relapsing or glucocorticoid-dependent minimal change disease?
→ ☐ Yes ☐ No Has the patient failed to attain a durable remission with cyclophosphamide or calcineurin inhibitors?
→ ☐ Yes ☐ No Does the patient have steroid-dependent, steroid-sensitive nephrotic syndrome?
→ ☐ Yes ☐ No Does the patient continue to have frequent relapses despite optimal combinations of prednisone and corticosteroid-sparing agents?
→ ☐ Yes ☐ No Has the patient had serious adverse effects from therapy?

☐ Yes ☐ No Is the patient's condition refractory to standard therapy (e.g., corticosteroids, immunosuppressants)?
→ ☐ Yes ☐ No Is there a clinical reason to avoid treatment with standard therapy?

Neuromyelitis optica (Devic's disease)

☐ Yes ☐ No Does the patient have a documented diagnosis of neuromyelitis optica (Devic's disease)?
☐ Yes ☐ No Will the requested medication be used after failing first-line treatment?

Oncologic indications

Please select which applies to the patient:

- ☐ B-cell acute lymphoblastic leukemia (ALL)
- ☐ B-cell lymphoblastic lymphoma
- ☐ Burkitt lymphoma
- ☐ Castleman disease (Multicentric; Unicentric)
- ☐ Chronic lymphocytic leukemia/Small lymphocytic lymphoma (CLL/SLL)
- ☐ Diffuse large B-cell lymphoma
- ☐ Follicle center lymphoma
- ☐ Follicular lymphoma
- ☐ Hairy cell leukemia
- ☐ HHV8-positive diffuse large B-cell lymphoma, not otherwise specified
- ☐ High grade B-cell lymphoma (including 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)
- ☐ Histologic transformation of indolent (follicular/nodal marginal zone) lymphomas to diffuse large B-cell lymphoma
- ☐ Histologic transformation of indolent lymphomas to high-grade B-cell lymphoma with MYC and BCL6 without BCL2 rearrangements
- ☐ Hodgkin's lymphoma
  - ☐ Yes ☐ No Is the disease relapsed or progressive?
  - ☐ Yes ☐ No Is the disease nodular lymphocyte-predominant?
- ☐ Human immunodeficiency virus (HIV)-related B-cell lymphoma
- ☐ Leptomeningeal metastases (from lymphomas)
- ☐ Malignant ascites with advanced low-grade non-Hodgkin lymphoma
- ☐ Mantle cell lymphoma
- ☐ Marginal zone lymphoma (nodal, extranodal [gastric and non-gastric MALT], splenic)
- ☐ Monomorphic (B-cell type) or polymorphic (B-cell type) post-transplant lymphoproliferative disorder
- ☐ Non–Hodgkin's lymphoma (NHL)
- ☐ Pediatric aggressive mature B-cell lymphomas
- ☐ Post-transplant lymphoproliferative disorders (PTLD)
- ☐ Primary central nervous system (CNS) lymphoma
- ☐ Primary cutaneous B-cell lymphoma
- ☐ Primary cutaneous marginal zone lymphoma
- ☐ Primary effusion lymphoma
- ☐ Primary mediastinal large B-cell lymphoma
- ☐ Rosai-Dorfman disease
- ☐ Waldenström macroglobulinemia/lymphoplasmacytic lymphoma/Bing-Neel-syndrome

☐ Yes ☐ No Has testing or analysis been performed to identify the CD20 protein on the surface of the B-cell?
☐ Yes ☐ No Is the cancer CD20 positive?

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

Pemphigus vulgaris

☐ Yes ☐ No Does the member have moderate to severe disease?

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Post-transplant lymphoproliferative disorder, including primary central nervous system post-transplant lymphoproliferative disorder

☐ Yes ☐ No Is rituximab being used as treatment of post-transplant lymphoproliferative disorder?

☐ Yes ☐ No Is rituximab being used as treatment of primary central nervous system post-transplant lymphoproliferative disorder?

Polyarteritis nodosa

☐ Yes ☐ No Has the member been diagnosed with severe, refractory polyarteritis nodosa?

Prevention of Epstein-Barr virus-related post-transplant lymphoproliferative disorders

☐ Yes ☐ No Is the member at high risk for post-transplant lymphoproliferative disease?

→ ☐ Yes ☐ No Has the member undergone an allogenic bone marrow transplant?

→ ☐ Yes ☐ No Will the member have prolonged T-cell impairment?

→ Has the member received one of the following treatments? ☐ Anti T-cell antibodies (alemtuzumab)
☐ Cord blood units or ex vivo CD34 selected or T-cell depleted hematopoietic cell grafts
☐ High-dose steroids for treatment of severe acute graft-versus-host disease ☐ None of the above

Primary central nervous system (CNS) post-transplant lymphoproliferative disorder

☐ Yes ☐ No Is the member at high risk for post-transplant lymphoproliferative disease?

Refractory bullous pemphigoid

☐ Yes ☐ No Will the requested medication be used after failing first-line treatment?

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 Has the patient been previously treated with a biologic or targeted synthetic disease-modifying anti-rheumatic drug (DMARD) (e.g., TNF inhibitor, JAK inhibitor) for rheumatoid arthritis?

→ ☐ Yes ☐ No Has the patient had an inadequate response to methotrexate or leflunomide?

→ ☐ Yes ☐ No Is there a clinical reason to avoid treatment with methotrexate or leflunomide (e.g., renal or hepatic impairment)?

→ ☐ Yes ☐ No Has the patient had an inadequate response to one or more tumor necrosis factor (TNF) antagonist therapies?

☐ Yes ☐ No Will rituximab be used in combination with methotrexate?

Sjögren's and systemic disease

☐ 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: ____/____/____ - ____/____/____

Systemic lupus erythematosus

☐ Yes ☐ No Does the patient have a diagnosis of systemic lupus erythematosus?

Thrombotic thrombocytopenic purpura

Please indicate the type of thrombotic thrombocytopenic purpura the patient is being treated for: ☐ Severe ☐ Refractory ☐ Relapsed ☐ Other

☐ Yes ☐ No Has the patient failed plasmaphereisis/plasma exchange?

☐ Yes ☐ No Has the patient failed glucocorticoids?

Thyroid eye disease (excluding patients with risk for dysthyroid optic neuropathy)

☐ Yes ☐ No Does the patient have moderate to severe thyroid eye disease?

→ ☐ Yes ☐ No Is the disease refractory to standard therapy (e.g., IV glucocorticoids)?

→ ☐ Yes ☐ No Is there a clinical reason to avoid standard therapy?

For Continuation Requests:

For rheumatoid arthritis only:

Please indicate the severity of the disease at baseline (pretreatment with rituximab: ☐ Mild ☐ Moderate ☐ Severe

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

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

For all other indications:

☐ 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.