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Rituxan® (rituximab) Medication Precertification Request

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

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

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 #: _____ Does patient have other coverage? ☐ Yes ☐ No

Group #: _____ If yes, provide ID#: _____ Carrier Name: _____

Insured: _____ Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

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 E-mail:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Rheumatologist** ☐ **Other**: _____

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: *Patient Selected choice*

☐ Physician's Office ☐ Retail Pharmacy

☐ Specialty Pharmacy ☐ Mail Order

☐ Other: _____

Name: _____

Address: _____

Phone: _____ Fax: _____

TIN: _____ PIN: _____

E. PRODUCT INFORMATION

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

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:

☐ Yes ☐ No Is/Will rituximab (Rituxan) 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 rituximab (Rituxan) 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 be given in conjunction with glucocorticoids?

Autoimmune blistering diseases, corticosteroid-refractory

Please select which applies to the patient: ☐ pemphigus vulgaris ☐ pemphigus folliaceus ☐ bullous pemphigoid ☐ cicatricial pemphigoid ☐ epidermolysis bullosa acquisita ☐ paraneoplastic pemphigus ☐ None of the above

☐ Yes ☐ No Does the patient have a documented diagnosis of corticosteroid-refractory autoimmune blistering disease?

Castleman's disease

☐ Yes ☐ No Does the patient have a documented diagnosis of multicentric Castleman's disease (angiofollicular lymph node hyperplasia)?

Chronic or small lymphocytic leukemia

Please select which applies to the patient: ☐ chronic lymphocytic leukemia (CLL) ☐ small lymphocytic leukemia

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 rituximab (Rituxan) being used as last-resort treatment for chronic graft versus host disease (GVHD)?

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Hairy cell leukemia

Please select which applies to the patient: ☐ relapsed hairy cell leukemia ☐ refractory hairy cell leukemia ☐ Other, please explain: _____

☐ Yes ☐ No Was treatment with at least two courses of cladribine ineffective?

Please provide the date range of course #1: Date range: ___/___/___ - ___/___/___

Please provide the date range of course #2: Date range: ___/___/___ - ___/___/___

Heart and solid organ transplant

Please select which applies to the patient: ☐ heart transplant recipient ☐ other solid organ transplant recipient

☐ Yes ☐ No Is there a documentation that rituximab (Rituxan) 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?

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 rituximab (Rituxan) 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)?

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?

Non-Hodgkin's lymphoma

☐ Yes ☐ No Does the patient have a documented diagnosis of non-Hodgkin's lymphoma (NHL)?

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 Does the patient have a documented diagnosis of post-transplant lymphoproliferative disorder?

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?

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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 Was treatment with Enbrel ineffective?
Please provide the date range of the trial: Date range: ____/____/____ - ____/____/____
☐ Yes ☐ No Was the treatment with Enbrel not tolerated or contraindicated? ☐ not tolerated ☐ contraindicated

☐ Yes ☐ No Was treatment with Inflectra ineffective?
Please provide the date range of the trial: Date range: ____/____/____ - ____/____/____
☐ Yes ☐ No Was the treatment with Inflectra not tolerated or contraindicated? ☐ not tolerated ☐ contraindicated

☐ Yes ☐ No Was treatment with Remicade ineffective?
Please provide the date range of the trial: Date range: ____/____/____ - ____/____/____
☐ Yes ☐ No Was the treatment with Remicade not tolerated or contraindicated? ☐ not tolerated ☐ contraindicated

☐ Yes ☐ No Was treatment with Renflexis ineffective?
Please provide the date range of the trial: Date range: ____/____/____ - ____/____/____
☐ Yes ☐ No Was the treatment with Renflexis not tolerated or contraindicated? ☐ not tolerated ☐ contraindicated

☐ Yes ☐ No Was treatment with Simponi ineffective?
Please provide the date range of the trial: Date range: ____/____/____ - ____/____/____
☐ Yes ☐ No Was the treatment with Simponi not tolerated or contraindicated? ☐ not tolerated ☐ contraindicated

☐ Yes ☐ No Was treatment with Simponi Aria ineffective?
Please provide the date range of the trial: Date range: ____/____/____ - ____/____/____
☐ Yes ☐ No Was the treatment with Simponi Aria not tolerated or contraindicated? ☐ not tolerated ☐ contraindicated

☐ Yes ☐ No Was treatment with Xeljanz/Xeljanz XR ineffective?
Please provide the date range of the trial: Date range: ____/____/____ - ____/____/____
☐ Yes ☐ No Was the treatment with Xeljanz/Xeljanz XR not tolerated or contraindicated? ☐ not tolerated ☐ contraindicated

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

For Continuation Request:

☐ Yes ☐ No Is this continuation request a result of the patient receiving samples of rituximab (Rituxan)? (Sampling of Rituxan does not guarantee coverage under the provisions of the pharmacy benefit)

Please indicate the length of time on rituximab (Rituxan): _____

For rheumatoid arthritis and multiple sclerosis only:

☐ 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.