aetna™

Truxima™ (rituximab-abbs) Medication Precertification Request

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

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

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: _____

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** ☐ **Oncologist** ☐ **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 ☐ Other _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: Truxima (rituximab-abbs) 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 (clinical documentation required for all requests):

Non-Oncology

☐ **Autoimmune hemolytic anemia**

☐ **Anti-neutrophil cytoplasmic antibody-associated (ANCA-associated) vasculitides**
Please indicate which of the following applies to the patient:
☐ Granulomatosis with polyangiitis (GPA) Wegener granulomatosis ☐ Churg-Strauss syndrome ☐ microscopic polyangiitis (MPA)
☐ pauci-immune glomerulonephritis

☐ **Autoimmune blistering diseases**
Please select which applies to the patient: ☐ pemphigus vulgaris ☐ pemphigus foliaceus ☐ bullous pemphigoid ☐ cicatricial pemphigoid
☐ epidermolysis bullosa acquisita ☐ paraneoplastic pemphigus ☐ None of the above
☐ Yes ☐ No Is the disease corticosteroid refractory?

☐ **Chronic graft versus host disease**

☐ **Cryoglobulinemia**
☐ Yes ☐ No Have corticosteroids and other immunosuppressive agents been ineffective?

☐ **Multiple sclerosis (MS)**
☐ Yes ☐ No Has the patient been diagnosed with relapsing-remitting multiple sclerosis (RRMS)?
☐ Yes ☐ No Is the patient taking the requested medication with any other medication used for the treatment of multiple sclerosis other than Ampyra?

☐ **Myasthenia gravis, refractory**

☐ **Neuromyelitis optica (Devic disease)**
☐ Yes ☐ No Has at least one other immunotherapy agent been ineffective?

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

☐ **Opsoclonus-myoclonus ataxia**
- ☐ Yes ☐ No Is the requested drug being used for neuroblastoma associated opsoclonus-myoclonus ataxia?
- ☐ Yes ☐ No Is the patient refractory to steroids and chemotherapy?

☐ **Prevention of Epstein-Barr virus (EBV) related post-transplant lymphoproliferative disorder (PTLD)**
- ☐ Yes ☐ No Is the requested drug being used for the prevention of Epstein-Barr virus (EBV) related post-transplant lymphoproliferative disorder (PTLD)?

☐ **Refractory immune or idiopathic thrombocytopenic purpura (ITP)**

☐ **Rheumatoid arthritis (RA)**

☐ Yes ☐ No Has the patient been diagnosed with moderately to severely active rheumatoid arthritis (RA)?

☐ Yes ☐ No Has the patient received a biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) that is indicated for moderately to severely active rheumatoid arthritis?
→ ☐ Yes ☐ No Has the patient received two full doses of the requested medication, with the most recent dose being 6 months before this request?
→ ☐ Yes ☐ No Has the patient experienced an inadequate response after at least 3 months of treatment with the methotrexate dose greater than or equal to 20 mg per week?
→ ☐ Yes ☐ No Has the patient experienced an inadequate response with another conventional DMARD (e.g., hydroxychloroquine, leflunomide, sulfasalazine)?

☐ Yes ☐ No Is the requested drug being prescribed in combination with methotrexate?
→ ☐ Yes ☐ No Has the patient experienced intolerance to methotrexate?
→ ☐ Yes ☐ No Does the patient have a contraindication to methotrexate?
→ Please indicate the contraindication: ☐ History of intolerance or adverse event ☐ Elevated liver transaminases ☐ Renal impairment ☐ Alcoholism, alcoholic liver disease or other chronic liver disease ☐ Interstitial pneumonitis or clinically significant pulmonary fibrosis ☐ Breastfeeding ☐ Pregnancy or planning pregnancy ☐ Myelodysplasia ☐ Hypersensitivity ☐ Significant drug interaction ☐ Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia) ☐ Other

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

☐ Yes ☐ No Is the planned date of administration at least 16 weeks after the date of the last dose received?

☐ Yes ☐ No Has the patient failed treatment with Rituxan and Ruxience?
→ ☐ Yes ☐ No Did the patient have a documented intolerable adverse event (e.g., rash, nausea, vomiting)?

☐ Yes ☐ No Was the adverse event not an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the brand and biosimilar medication)?

☐ **Sjögren's syndrome**
- ☐ Yes ☐ No Was treatment with corticosteroids and other immunosuppressive agents ineffective?

☐ **Solid organ transplant, treat and prevention**
- ☐ Yes ☐ No Is the requested drug being used for the treatment and prevention of antibody mediated rejection in solid organ transplant?

☐ **Systemic Lupus Erythematosus**
- ☐ Yes ☐ No Is the patient refractory to immunosuppressive therapy?

☐ **Thrombotic thrombocytopenic purpura (TTP)**

Non- Hodgkin's Lymphoma (NHL)

Please indicate the patient's documented diagnosis:

☐ Acquired immunodeficiency syndrome (AIDS)-related B-cell lymphoma ☐ B-cell lymphoblastic lymphoma ☐ Burkitt lymphoma ☐ Castleman's disease
☐ Chronic lymphocytic leukemia (CLL) ☐ Diffuse large B-cell lymphoma (DLBCL) ☐ Follicular lymphoma ☐ Hairy cell leukemia
☐ 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 ☐ Mantle cell lymphoma
☐ Marginal zone lymphoma (nodal, splenic or gastric/non-gastric mucosa-associated lymphoid tissue [MALT] lymphoma)
☐ Post-transplant lymphoproliferative disorder (PTLD) ☐ Primary cutaneous B-cell lymphoma ☐ Small lymphocytic lymphoma (SLL)

☐ Yes ☐ No 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**.

Other Oncology

Please indicate the patient's documented diagnosis:

☐ Immune Checkpoint Inhibitor-related toxicities
For ☐ Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma (LPL) ☐ Hodgkin's lymphoma, nodular lymphocyte-predominant
☐ Central nervous system (CNS) cancers with primary central nervous system (CNS) lymphoma
☐ Central nervous system (CNS) cancers with leptomeningeal metastases from lymphomas ☐ B-cell acute lymphoblastic leukemia (ALL):

☐ Yes ☐ No 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**.

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For Continuation Requests:

Rheumatoid Arthritis (RA)

☐ Yes ☐ No Is this continuation request a result of the patient receiving samples or a manufacturer's patient assistance program? (Sampling of the medication does not guarantee coverage under the provisions of the pharmacy benefit)

Please indicate the number of total doses the patient has received since starting treatment with the requested medication: _____

☐ Yes ☐ No Will the requested medication be used with another biologic for the treatment of rheumatoid arthritis?

☐ Yes ☐ No Has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of rheumatoid arthritis since starting treatment with the requested medication?

Multiple sclerosis (MS)

☐ Yes ☐ No Is the patient experiencing disease stability or improvement while receiving the requested medication?

Continuation, oncologic indications

☐ Yes ☐ No Has the patient experienced an unacceptable toxicity from treatment with the requested drug?

Continuation, immune checkpoint inhibitor-related toxicities and all other indications

☐ Yes ☐ No Is the patient experiencing benefit from therapy?

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.