



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

Page 1 of 3

(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, Rituxan Hycela, and Ruxience are preferred. Riabni and Truxima are non-preferred. For rheumatoid arthritis, all Rituxan and biosimilar products are non-preferred.

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 #: _____	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured: _____	Insured: _____

C. PRESCRIBER INFORMATION				
First Name:		Last Name:		(Check one): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.
Address:		City:	State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:
Office Contact Name:			Phone:	

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION	
<b>Place of Administration:</b> <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Home <input type="checkbox"/> Outpatient Infusion Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____ NPI: _____	<b>Dispensing Provider/Pharmacy:</b> <input type="checkbox"/> Outpatient Dialysis Center <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Mail Order <input type="checkbox"/> Other: _____ Name: _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____ NPI: _____

E. PRODUCT INFORMATION		
Request is for: <input type="checkbox"/> Riabni (rituximab-arrx) <input type="checkbox"/> Rituxan (rituximab) <input type="checkbox"/> Ruxience (rituximab-pvvr) <input type="checkbox"/> Truxima (rituximab-abbs)		
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: _____	<input type="checkbox"/> Other ICD Code: _____

G. CLINICAL INFORMATION - Required clinical information must be completed for ALL precertification requests.	
<b>For All Requests (clinical documentation required for all requests):</b>	
Note: Rituxan, Rituxan Hycela, and Ruxience are preferred for most indications. Riabni and Truxima are non-preferred. For rheumatoid arthritis, all Rituxan and biosimilar products are non-preferred. Avsola, Remicade, and Simponi Aria are preferred for MA plans. Enbrel, Humira, Rinvoq, and Xeljanz/Xeljanz XR are preferred for MAPD plans.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient had prior therapy with Riabni (rituximab-arrx) or Truxima (rituximab-abbs) within the last 365 days?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient had a trial, intolerance, or contraindication to any of the following? (select all that apply)
	<input type="checkbox"/> Rituxan (rituximab) <input type="checkbox"/> Rituxan Hycela (rituximab/hyaluronidase human) <input type="checkbox"/> Ruxience (rituximab-pvvr)
Please explain if there are 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) <input type="checkbox"/> Rituxan (rituximab) <input type="checkbox"/> Rituxan Hycela (rituximab/hyaluronidase human) <input type="checkbox"/> Ruxience (rituximab-pvvr)	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient had prior therapy with Rituxan (rituximab), Rituxan Hycela (rituximab-arrx), Ruxience (rituximab-pvvr), Riabni (rituximab-arrx) or Truxima (rituximab-abbs) within the last 365 days?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient had a trial, intolerance, or contraindication to any of the following? (select all that apply)
	<input type="checkbox"/> Remicade (infliximab) <input type="checkbox"/> Avsola (infliximab-axxq) <input type="checkbox"/> Simponi Aria (golimumab)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient had a trial, intolerance, or contraindication to any of the following? (select all that apply)
	<input type="checkbox"/> Enbrel (etanercept) <input type="checkbox"/> Humira (adalimumab) <input type="checkbox"/> Rinvoq (upadacitinib) <input type="checkbox"/> Xeljanz/Xeljanz XR (tofacitinib)
Please explain if there are 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) <input type="checkbox"/> Remicade (infliximab) <input type="checkbox"/> Avsola (infliximab-axxq) <input type="checkbox"/> Simponi Aria (golimumab)	
Please explain if there are 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) <input type="checkbox"/> Enbrel (etanercept) <input type="checkbox"/> Humira (adalimumab) <input type="checkbox"/> Rinvoq (upadacitinib) <input type="checkbox"/> Xeljanz/Xeljanz XR (tofacitinib)	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will Rituxan (rituximab) be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, infliximab)?

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# MEDICARE FORM

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

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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### G. CLINICAL INFORMATION (Continued) - Required clinical information must be completed for ALL precertification requests.

#### 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 foliaceus  bullous pemphigoid  cicatricial pemphigoid  
 epidermolysis bullosa acquisita  paraneoplastic pemphigus  None of the above

#### 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)?

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# MEDICARE FORM

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

#### 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?

#### 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

Yes  No Was treatment with another conventional DMARD ineffective?  
 Please select:  azathioprine  cyclosporine  hydroxychloroquine  leflunomide  sulfasalazine

#### 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 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?

#### 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.