



# Truxima™ (rituximab-abbs) Medication Precertification Request

Page 1 of 3

(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: _____ 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: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____

## 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 #: _____	UPIN: _____
Provider E-mail: _____		Office Contact Name: _____		Phone: _____	
Specialty (Check one): <input type="checkbox"/> Rheumatologist <input type="checkbox"/> Oncologist <input type="checkbox"/> Other: _____					

## D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

<b>Place of Administration:</b> <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____	<b>Dispensing Provider/Pharmacy: Patient Selected choice</b> <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other _____ Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____
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## 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

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

Chronic graft versus host disease

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

Churg-Strauss syndrome

Granulomatosis with polyangiitis (GPA) (Wegener's granulomatosis)

Immune Checkpoint Inhibitor-related toxicities

Immune or idiopathic thrombocytopenic purpura (ITP), refractory

Microscopic polyangiitis (MPA)

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 (i.e., neuromyelitis optica spectrum disorder (NMOSD), Devic disease)  
 Yes  No Has at least one other immunotherapy agent been ineffective?  
 Yes  No Will the requested drug be used concomitantly with another biologic for the treatment of neuromyelitis optica spectrum disorder (NMOSD)?

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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 associated opsoclonus-myoclonus ataxia associated with neuroblastoma?  
 Yes  No Is the patient refractory to steroids and chemotherapy?

**Pauci-immune glomerulonephritis**

**Prevention of Epstein-Barr virus (EBV) related post-transplant lymphoproliferative disorder (PTLD)**

**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 Does the patient meet either of the following: a) the patient was tested for the rheumatoid factor (RF) biomarker and the RF biomarker test was positive, or b) the patient was tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker and the anti-CCP biomarker test was positive?  
             →  Yes  No Has the patient been tested for all of the following biomarkers: a) rheumatoid factor (RF), b) anti-cyclic citrullinated peptide (anti-CCP), and c) C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR)?

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 15 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 or leflunomide?  
     →  Yes  No Has the patient experienced intolerance to methotrexate or leflunomide?  
         →  Yes  No Does the patient have a contraindication to methotrexate or leflunomide?  
             → Please indicate the contraindication:  
                  History of intolerance or adverse event    Renal impairment    Hypersensitivity  
                  Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)  
                  Breastfeeding    Elevated liver transaminases    Myelodysplasia  
                  Interstitial pneumonitis or clinically significant pulmonary fibrosis  
                  Pregnancy or currently planning pregnancy    Significant drug interaction  
                  Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease  
                  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?

**Sjögren's syndrome**  
 Yes  No Have corticosteroids and other immunosuppressive agents been ineffective?

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

**Systemic Lupus Erythematosus (SLE)**  
 Yes  No Is the disease refractory to immunosuppressive therapy?

**Thrombotic thrombocytopenic purpura (TTP)**

**Oncology:**  
 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.**

Please indicate the patient's documented diagnosis:  
 Acquired immunodeficiency syndrome (AIDS)-related B-cell lymphoma  
 B-cell acute lymphoblastic leukemia (ALL)  
 B-cell lymphoblastic lymphoma  
 Burkitt lymphoma  
 Castleman's disease  
 Central nervous system (CNS) cancers with leptomeningeal metastases from lymphomas  
 Central nervous system (CNS) cancers with primary central nervous system (CNS) lymphoma  
 Chronic lymphocytic leukemia (CLL)  
 Diffuse large B-cell lymphoma (DLBCL)  
 Follicular lymphoma

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

- 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
- Histological transformation from follicular lymphoma to diffuse large B-cell lymphoma
- Histological transformation from nodal marginal zone lymphoma to diffuse large B-cell lymphoma
- Hodgkin's lymphoma, nodular lymphocyte-predominant
- Mantle cell lymphoma
- Marginal zone lymphomas (nodal marginal zone lymphoma, gastric mucosa associated lymphoid tissue (MALT) lymphoma, nongastric MALT lymphoma, splenic marginal zone lymphoma)
- Pediatric Aggressive Mature B-Cell Lymphomas
- Post-transplant lymphoproliferative disorder (PTLD)
- Primary cutaneous B-cell lymphoma
- Rosai-Dorfman disease
- Small lymphocytic lymphoma (SLL)
- Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma (LPL)

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

**Rheumatoid Arthritis (RA)**

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?

Please indicate the percent of disease activity improvement from baseline in tender joint count, swollen joint count, pain, or disability: \_\_\_\_\_ %

**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.