



# Riabni™ (rituximab-arrx) 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:  Riabni (rituximab-arrx) 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):

Yes  No Has the patient failed treatment with Truxima due to a documented intolerable adverse event (e.g., rash, nausea, vomiting)?  
 Yes  No Was the adverse event unexpected and not attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the brand and biosimilar medication )?

### 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

Continued on next page



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

- 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)?
  - Opsoclonus-myoelonus ataxia**
    - Yes  No Is the requested drug being used for associated opsoclonus-myoelonus 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 Has the patient been tested for the rheumatoid factor (RF) biomarker?  
Please indicate the test result:  positive  negative  not completed
        - Yes  No Has the patient been tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker?  
Please indicate the test result:  positive  negative  not completed
        - Yes  No Has the patient been tested for the C-reactive protein (CRP) biomarker?  
Please indicate the test result:  positive  negative  not completed
        - Yes  No Has the patient been tested for the erythrocyte sedimentation rate (ESR) biomarker?  
Please indicate the test result:  positive  negative  not completed
        - 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

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

- 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
- 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):**

- Yes  No Has the patient failed treatment with Truxima due to a documented intolerable adverse event (e.g., rash, nausea, vomiting)?
- Yes  No Was the adverse event unexpected and not attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the brand and biosimilar medication)

**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.