



**Truxima™ (rituximab-abbs),
Riabni™ (rituximab-arrx)
Medication Precertification Request**

Aetna Precertification Notification

Phone: 1-866-752-7021

FAX: 1-888-267-3277

**For Medicare Advantage Part B:
Please Use Medicare Request Form**

Page 1 of 3

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

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

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

E. PRODUCT INFORMATION

Request is for: Truxima (rituximab-abbs) 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):

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-myooclonus ataxia
 Yes No Is the requested drug being used for associated opsoclonus-myooclonus 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 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 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?
 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 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

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

- Central nervous system (CNS) cancers with primary central nervous system (CNS) lymphoma
- 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):

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.