Rituxan, Ruxience, Truxima, Riabni

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to Priority Partners, toll-free at 1-866-212-4756** to initiate the review process. If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ Same as Referring Provider ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical (POS Code 24)*
❑ *Home (POS Code 12)*
❑ *Off Campus Outpatient Hospital (POS Code 19)*
❑ *On Campus Outpatient Hospital (POS Code 22)*
❑ *Office (POS Code 11)*

Drug Information:

Strength/Measure _____*Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
Directions(sig) _____*Route of administration* _____
Dosing frequency _____

What is the ICD-10 code? _____

Site of Service Questions:

A. Indicate the site of service requested:
❑ On Campus Outpatient Hospital
❑ Off Campus Outpatient Hospital
❑ Home based setting, *skip to Criteria Questions*
❑ Community office, *skip to Criteria Questions*
❑ Ambulatory infusion site, *skip to Criteria Questions*

B. Is the patient less than 18 years of age?

Send completed form to: Priority Partners Fax: 1-866-212-4756

 JHHC SOC Rituxan, Ruxience, Truxima, Riabni SGM 1704-A – 02/2024.

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.hopkinshealthplans.org

❑ Yes, *skip to Clinical Criteria Questions*
❑ No

C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, other pre- medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

D. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

F. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

G. Has the patient's home been deemed not eligible or appropriate for home infusion services by a home infusion provider? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

H. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?
ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation. ❑ Yes ❑ No

Clinical Criteria Questions:

1. What is the diagnosis?

❒ Autoimmune blistering disease (e.g., pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, cicatricial pemphigoid, epidermolysis bullosa acquisita and paraneoplastic pemphigus), *Continue to 7*

❒ Autoimmune hemolytic anemia, *Continue to 10*

❒ B-cell acute lymphoblastic leukemia (ALL), CD20 positive, *Continue to 2*

❒ B-cell lymphoblastic lymphoma, CD20 positive, *Continue to 2*

❒ Burkitt lymphoma, CD20 positive, *Continue to 2*

❒ Castleman's disease, CD20 positive, *Continue to 2*

❒ Chronic graft versus host disease, *Continue to 10*

❒ Chronic lymphocytic leukemia (CLL), CD20 positive, *Continue to 2*

❒ Churg-Strauss syndrome, *Continue to 9*

❒ Cryoglobulinemia, *Continue to 49*

❒ Diffuse large B-cell lymphoma (DLBCL), CD20 positive, *Continue to 2*

❒ Extranodal marginal zone lymphoma (gastric and non-gastric MALT lymphoma), *Continue to 2*

❒ Follicular lymphoma, CD20 positive, *Continue to 2*

❒ Granulomatosis with polyangiitis (GPA) (Wegener's granulomatosis), *Continue to 9*

❒ Hairy cell leukemia, CD20 positive, *Continue to 2*

❒ High-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 (double/triple hit lymphoma), CD20 positive, *Continue to 2*

❒ High-grade B-cell lymphoma, not otherwise specified, CD20 positive, *Continue to 2*

❒ Histological transformation from follicular lymphoma to diffuse large B-cell lymphoma, CD20 positive, *Continue to 2*

❒ Histological transformation from nodal marginal zone lymphoma to diffuse large B-cell lymphoma, CD20 positive, *Continue to 2*

❒ HIV-related B-cell lymphoma, CD20 positive, *Continue to 2*

❒ Hodgkin's lymphoma, nodular lymphocyte-predominant, CD20 positive, *Continue to 2*

❒ Immune checkpoint inhibitor-related toxicities, *Continue to 5*

❒ Immune or idiopathic thrombocytopenic purpura (ITP), refractory, *Continue to 10*

❒ Leptomeningeal metastases from lymphomas, CD20 positive, *Continue to 2*

❒ Mantle cell lymphoma, CD20 positive, *Continue to 2*

❒ Nodal marginal zone lymphoma, CD20 positive, *Continue to 2*

❒ Microscopic polyangiitis (MPA), *Continue to 9*

❒ Multiple sclerosis (MS), *Continue to 38*

❒ Myasthenia gravis, refractory, *Continue to 8*

❒ Neuromyelitis optica (i.e., neuromyelitis optica spectrum disorder [NMOSD], Devic disease), *Continue to 46*

❒ Opsoclonus-myoclonus ataxia, *Continue to 55*

❒ Pauci-immune glomerulonephritis, *Continue to 9*

❒ Pediatric aggressive mature B-cell lymphomas, CD20 positive, *Continue to 2*

❒ Post-transplant lymphoproliferative disorder (PTLD), CD20 positive, *Continue to 2*

❒ Prevention of Epstein-Barr virus (EBV) related post-transplant lymphoproliferative disorder (PTLD), *Continue to 10*

❒ Primary central nervous system (CNS) lymphoma, CD20 positive, *Continue to 2*

❒ Primary cutaneous B-cell lymphoma, CD20 positive, *Continue to 2*

❒ Primary Mediastinal Large B-Cell Lymphoma, CD20 positive, *Continue to 2*

❒ Rheumatoid arthritis (RA), *Continue to 16*

❒ Rosai-Dorfman disease,CD20 positive, *Continue to 2*

❒ Sjogren's syndrome, *Continue to 43*

❒ Small lymphocytic lymphoma (SLL), CD20 positive, *Continue to 2*

❒ Solid organ transplant and prevention of antibody mediated rejection in solid organ transplant, *Continue to 52*

❒ Systemic lupus erythematosus (SLE), *Continue to 12*

❒ Thrombotic thrombocytopenic purpura (TTP), *Continue to 10*

❒ Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma (LPL), CD20 positive, *Continue to 2*

❒ Other, please specify. _____, *No further questions*

2. Is this a request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 4*
❒ No, *Continue to 3*

3. Does the patient have CD20 positive disease that was confirmed by testing or analysis? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results confirming CD20 protein on the surface of the B-cell.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ No, *No further questions*

❒ Unknown, *No further questions*

4. Is there evidence of unacceptable toxicity while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

5. Is this a request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 6*
❒ No, *No Further Questions*

6. Is the patient experiencing benefit from therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

7. Will the requested drug be prescribed by or in consultation with a dermatologist or immunologist?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

8. Will the requested drug be prescribed by or in consultation with a neurologist, rheumatologist, or immunologist?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

9. Will the requested drug be prescribed by or in consultation with a rheumatologist, immunologist, or nephrologist?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. Is this a request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 11*
❒ No, *No Further Questions*

11. Is the patient experiencing benefit from therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

12. Is the disease refractory to immunosuppressive therapy? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

13. Will the requested drug be prescribed by or in consultation with a rheumatologist, immunologist, or nephrologist?
❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. Is this a request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 15*
❒ No, *No Further Questions*

15. Is the patient experiencing benefit from therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

16. What is the patient's age?

❒ 18 years of age or older, *Continue to 17*

❒ Less than 18 years of age, *Continue to 17*

17. Has the patient been diagnosed with moderately to severely active rheumatoid arthritis (RA)?
❒ Yes, *Continue to 18*
❒ No, *Continue to 18*

18. Has the patient previously received a biologic or targeted synthetic drug (e.g., Rinvoq, Xeljanz) that is indicated for moderately to severely active rheumatoid arthritis? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 27*
❒ No, *Continue to 19*

19. Has the patient received at least two full doses of the requested medication, with the most recent dose being within 6 months of this request?
❒ Yes, *Continue to 27*
❒ No, *Continue to 20*

20. 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? ***ACTION REQUIRED***: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 22*
❒ No, *Continue to 21*

21. 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)? ***ACTION REQUIRED***: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 22*
❒ No, *Continue to 22*

22. Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate at a dose greater than or equal to 15 mg per week? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 27*
❒ No, *Continue to 23*

23. Has the patient experienced an intolerance to methotrexate or leflunomide? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 26*
❒ No, *Continue to 24*

24. Does the patient have a contraindication to methotrexate or leflunomide? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 25*
❒ No, *Continue to 26*

25. Please indicate the contraindication.

❒ History of intolerance or adverse event, *Continue to 26*

❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease, *Continue to 26*

❒ Elevated liver transaminases, *Continue to 26*

❒ Interstitial pneumonitis or clinically significant pulmonary fibrosis, *Continue to 26*

❒ Renal impairment, *Continue to 26*

❒ Pregnancy or currently planning pregnancy, *Continue to 26*

❒ Breastfeeding, *Continue to 26*

❒ Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia), *Continue to 26*

❒ Myelodysplasia, *Continue to 26*

❒ Hypersensitivity, *Continue to 26*

❒ Significant drug interaction, *Continue to 26*

❒ Other, please specify. _____, *Continue to 26*

26. Has the patient experienced an inadequate response with another conventional drug (e.g., hydroxychloroquine, leflunomide, sulfasalazine)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation

❒ Yes, *Continue to 31*
❒ No, *Continue to 31*

27. Is the requested drug being prescribed in combination with methotrexate or leflunomide?
❒ Yes, *Continue to 31*
❒ No, *Continue to 28*

28. Has the patient experienced an intolerance to methotrexate or leflunomide? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 31*
❒ No, *Continue to 29*

29. Does the patient have a contraindication to methotrexate or leflunomide? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 30*
❒ No, *Continue to 31*

30. Please indicate the contraindication.
❒ History of intolerance or adverse event, *Continue to 31*
❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease, *Continue to 31*
❒ Elevated liver transaminases, *Continue to 31*
❒ Interstitial pneumonitis or clinically significant pulmonary fibrosis, *Continue to 31*
❒ Renal impairment, *Continue to 31*
❒ Pregnancy or currently planning pregnancy, *Continue to 31*
❒ Breastfeeding, *Continue to 31*
❒ Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia), *Continue to 31*
❒ Myelodysplasia, *Continue to 31*
❒ Hypersensitivity, *Continue to 31*
❒ Significant drug interaction, *Continue to 31*
❒ Other, please specify. _____, *Continue to 31*

31. Will the requested drug be used with another biologic for the treatment of rheumatoid arthritis?
❒ Yes, *Continue to 33*
❒ No, *Continue to 32*

32. Is the planned date of administration at least 16 weeks after the date of the last dose received?
❒ Yes, *Continue to 33*
❒ No, *Continue to 33*
❒ Not applicable - Patient has not received any previous doses, *Continue to 33*

33. Will the requested drug be prescribed by or in consultation with a rheumatologist, immunologist, or nephrologist?
❒ Yes, *Continue to 34*
❒ No, *Continue to 34*

34. Is this request for continuation of therapy?
❒ Yes, *Continue to 35*
❒ No, *No Further Questions*

35. How many doses in total has the patient received since starting treatment with the requested medication?
❒ 1 dose, *No further questions*
❒ 2 doses (one complete course) or more, *Continue to 36*

36. Has the patient achieved or maintained positive clinical response since starting treatment with the requested medication?
❒ Yes, *Continue to 37*
❒ No, *Continue to 37*

37. What is the percent of disease activity improvement from baseline in tender joint count, swollen joint count, pain, or disability? ***ACTION REQUIRED***: Please attach chart notes or medical record documentation supporting positive clinical response.
_____% ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

38. Has the patient been diagnosed with relapsing-remitting multiple sclerosis (RRMS)?
❒ Yes, *Continue to 39*
❒ No, *Continue to 39*

39. Is the patient taking the requested medication with any other medication used for the treatment of multiple sclerosis other than Ampyra?
❒ Yes, *Continue to 40*
❒ No, *Continue to 40*

40. Will the requested drug be prescribed by or in consultation with a neurologist, rheumatologist, or immunologist?
❒ Yes, *Continue to 41*
❒ No, *Continue to 41*

41. Is this a request for continuation of therapy?
❒ Yes, *Continue to 42*
❒ No, *No Further Questions*

42. Is the patient experiencing disease stability or improvement while receiving the requested medication?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

43. Have corticosteroids and other immunosuppressive agents been ineffective? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 44*
❒ No, *Continue to 44*

44. Will the requested drug be prescribed by or in consultation with a rheumatologist, ophthalmologist, or immunologist?
❒ Yes, *Continue to 45*
❒ No, *Continue to 45*

45. Is this a request for continuation of therapy?
❒ Yes, *Continue to 59*
❒ No, *No Further Questions*

46. Will the requested drug be prescribed by or in consultation with a neurologist, rheumatologist, or immunologist?
❒ Yes, *Continue to 47*
❒ No, *Continue to 47*

47. Will the patient receive the requested drug concomitantly with other biologics for the treatment of neuromyelitis optica spectrum disorder (NMOSD)?
❒ Yes, *Continue to 48*
❒ No, *Continue to 48*

48. Is this a request for continuation of therapy?
❒ Yes, *Continue to 59*
❒ No, *No Further Questions*

49. Have corticosteroids and other immunosuppressive agents been ineffective? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 50*
❒ No, *Continue to 50*

50. Will the requested drug be prescribed by or in consultation with a hematologist, rheumatologist, neurologist, or nephrologist?
❒ Yes, *Continue to 51*
❒ No, *Continue to 51*

51. Is this a request for continuation of therapy?
❒ Yes, *Continue to 59*
❒ No, *No Further Questions*

52. Is the requested drug being used for the prevention of antibody mediated rejection in solid organ transplant?

❒ Yes, *Continue to 53*
❒ No, *Continue to 53*

53. Will the requested drug be prescribed by or in consultation with an immunologist or transplant specialist?
❒ Yes, *Continue to 54*
❒ No, *Continue to 54*

54. Is this a request for continuation of therapy?
❒ Yes, *Continue to 59*
❒ No, *No Further Questions*

55. Is the requested drug being used for opsoclonus-myoclonus-ataxia associated with neuroblastoma?
❒ Yes, *Continue to 56*
❒ No, *Continue to 56*

56. Is the patient refractory to steroids and chemotherapy? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 57*
❒ No, *Continue to 57*

57. Will the requested drug be prescribed by or in consultation with a neurologist, rheumatologist, or immunologist?
❒ Yes, *Continue to 58*
❒ No, *Continue to 58*

58. Is this a request for continuation of therapy?
❒ Yes, *Continue to 59*
❒ No, *No Further Questions*

59. Is the patient experiencing benefit from therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Priority Partners Fax: 1-866-212-4756