MEDICAL DRUG BENEFIT
PRIOR AUTHORIZATION REQUESTS

Ruxience, Truxima, Rituxtan, Rituxan Hycela or Riabni

Version 1.0 Effective: 05/01/2022

Phone: 1-877-417-1822 (MassHealth) **Fax back to: 1-866-539-7185**

1-877-417- 0528 (QHP)

** Some plans might not accept this form for Medicare or Medicaid requests*

This form is being used for:	
Check if Expedited Review/Urgent Request:	☐ (In checking this box, I attest to the fact that this request meets the definition and criteria for expedited review and is an urgent request.)

1. Patient Information		
Patient Name:	DOB:	
Member ID #:		

2. Prescriber Information	
Prescribing Clinician:	Phone #:
Specialty:	Secure Fax #:
NPI #:	DEA/xDEA:
Prescriber Point of Contact Name (POC) (if different than provider):	
POC Phone #:	POC Secure Fax #:
POC Email (not required):	
Prescribing Clinician or Authorized Representative Signature:	Date:

3. Drug Request	
Please select the drug you are requesting (*select one*):	
☐ Ruxience (Proceed to Q4, then Q8)	☐ Rituxan Hycela (Proceed to Q4, then Q6)
☐ Rituxan (Proceed to Q4, then Q5)	☐ Riabni (Proceed to Q4, then Q5)
☐ Truxima (Proceed to Q4, then Q8)	

4. Requested Dosing
Please document the requested dosing:

5. For Rituxan or Riabni
Please choose *ALL* of the following that apply (proceed to Q8):
☐ Member has tried Ruxience or Truxima or both
☐ Member cannot continue use with Ruxience or Truxima due to a formulation difference in the INACTIVE ingredient(s) that would result in a significant allergy or adverse effect (e.g., differences in stabilizing agent, buffering agent, and/or surfactant)
☐ Member has already started on or has previously received the requested rituximab intravenous product
☐ Other clinical information *(please specify):*

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6. For Rituxan Hycela
Is the member using it for the following conditions? Please select *ANY* of the following that apply (Proceed to Q7)
☐ Granulomatosis with Polyangiitis (Wegener's granulomatosis) or Microscopic Polyangiitis
☐ Pemphigus Vulgaris
☐ Rheumatoid Arthritis
☐ None of the above

7. For Rituxan Hycela
Please choose *ALL* of the following that apply: (Proceed to Q9)
☐ Member has tried Ruxience or Truxima or both, but, according to the prescriber, cannot continue to use this product
☐ Member cannot use rituximab intravenous due to an inability to obtain or maintain intravenous access
☐ Member has already started on or has previously received Rituxan Hycela
☐ Other clinical information (*please specify*):

8. Diagnosis- For Ruxience, Rituxan, Riabni or Truxima
What is the diagnosis the requested medication is being used to treat (*select one*):
☐ Antineutrophil Cytoplasmic Antibody (ANCA)-Associated Vasculitis(Proceed to Q10)
☐ Acute Lymphoblastic Leukemia (Proceed to Q13)
☐ B-Cell Lymphoma (Proceed to Q21)
☐ Chronic Lymphocytic Leukemia or Small Lymphocytic Lymphoma (Proceed to Q21)
☐ Graft-Versus-Host Disease (Proceed to Q14)
☐ Hairy Cell Leukemia (Proceed to Q21)
☐ Hodgkin Lymphoma(Proceed to Q15)
☐ Immune Thrombocytopenia (ITP) (Proceed to Q16)
☐ Multiple Sclerosis (Proceed to Q17)
☐ Neuromyelitis Optica Spectrum Disorder(Proceed to Q21)
☐ Pemphigus Vulgaris(Proceed to Q11)
☐ Primary Central Nervous System Lymphoma(Proceed to Q21)
☐ Rheumatoid Arthritis (Proceed to Q12)
☐ Systemic Lupus Erythematous (Proceed to Q18)
☐ Waldenstrom's Macroglobulinemia/Lymphoplasmacytic Lymphoma (Proceed to Q21)
☐ Other, *please indicate diagnosis* below and include supporting clinical documentation for use in this indication and attached applicable chart notes in faxed request detailing member's clinical status, dose and dates of all previous therapies and outcomes, proper succession of therapies that have been tried and failed and any related lab work and test results:

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9. Diagnosis- For Rituxan Hycela
What is the diagnosis the requested medication is being used to treat (*select one*):
☐ B-Cell Lymphoma (proceed to Q20)
☐ Chronic Lymphocytic Leukemia or Small Lymphocytic Lymphoma (Proceed to Q20)
☐ Hairy Cell Leukemia (proceed to Q19)
☐ Waldenstrom's Macroglobulinemia/Lymphoplasmacytic Lymphoma (Proceed to Q20)
☐ Other, *please indicate diagnosis below* and include supporting clinical documentation for use in this indication and attach applicable chart notes in faxed request detailing member's clinical status, dose and dates of all previous therapies and outcomes, proper succession of therapies that have been tried and failed and any related lab work and test results.

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10. For ANCA-Associated Vasculitis
Please choose *ALL* of the following that apply: (Proceed to Q21)
☐ Member has an ANCA-associated vasculotide (e.g granulomatosis with polyangiitis (GPA) [Wegener's granulomatosis] or microscopic polyangiitis (MPA)
☐ The medication is being administered in combination with glucocorticoids
☐ Other *(please specify)*:

11. For Pemphigus Vulgaris
Will the therapy be initiated in combination with a corticosteroid unless contraindicated? (Proceed to Q21)
☐ Yes
☐ No

12. For Rheumatoid Arthritis
Please choose *ALL* of the following that apply (Proceed to Q21)
☐ Member has tried ONE conventional synthetic disease-modifying antirheumatic drug (DMARD) for at least 3 months (e.g methotrexate, leflunomide, hydroxychloroquine, and sulfasalazine)
☐ Member has tried 3-months of at least one biologic
☐ The medication will not be used concurrently with another biologic or with a targeted synthetic DMARD
☐ Other (please specify):

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13. For Acute Lymphoblastic Leukemia
Does the member have CD20-positive disease? (Proceed to Q21)
☐ Yes
☐ No

14. For Graft Vs Host Disease
Has the member tried at least one conventional systemic treatment for graft versus host disease? (e.g. corticosteroids, cyclosporine, tacrolimus, mycophenolate mofetil, Imbruvica, imatinib, antithymocyte globulin, Nipent or an infliximab product) (Proceed to Q21)
☐ Yes
☐ No

15. For Hodgkin Lymphoma
Does the member have nodular lymphocyte predominant disease? (Proceed to Q21)
☐ Yes
☐ No

16. For Immune Thrombocytopenia (ITP)
Has the member tried one other therapy for the condition? (e.g. intravenous immunoglobulin, anti-D (RHO) immunoglobulin, corticosteroids, and splenectomy)? (Proceed to Q21)
☐ Yes
☐ No

17. For Multiple Sclerosis
Please choose ALL of the following that apply: (Proceed to Q21)
☐ Member has had an inadequate response or was unable to tolerate at least ONE other disease-modifying agent for multiple sclerosis; AND
☐ The medication will not be used concurrently with another disease-modifying agent used for multiple sclerosis
☐ At least 6 months will elapse between treatment courses
☐ Other (*please specify*):

18. For Systemic Lupus Erythematous
Has the member tried at least ONE standard immunomodulating or immunosuppressant agent? (e.g. hydroxychloroquine, corticosteroids, methotrexate, azathioprine, mycophenolate, and cyclophosphamide) (Proceed to Q21)
☐ Yes
☐ No

19. If Rituxan Hycela and selected diagnosis is Hairy Cell Leukemia
Has the member had relapsed/refractory hairy cell leukemia? (Proceed to Q20)
☐ Yes
☐ No

20. If the selected drug is Rituxan Hycela
Please choose ALL of the following that apply: (Proceed to Q21)
☐ Member has already received at least one full dose of rituximab intravenous therapy
☐ Rituxan Hycela is administered under the care of a healthcare professional
☐ Other (*please specify*):

21. Specialty of the Prescriber	
Please indicate what specialty the prescriber is *(select any that apply)*:	
☐ Hematologist	☐ Immunologist
☐ Nephrologist	☐ Neurologist
☐ Oncologist	☐ Rheumatologist
☐ Other *(please indicate what specialty below):*	

22. Initial or Continuing Therapy
Is the request for initial or continuing therapy?
☐ Initial (Proceed to Q29)
☐ Continuation (Proceed to Q23)

23. Continuation of Therapy- Diagnosis	
Please select the appropriate diagnosis:	
☐ ANCA-Associated Vasculitis (proceed to Q24)	☐ Pemphigus Vulgaris (Proceed to Q25)
☐ Rheumatoid Arthritis (Proceed to Q26)	☐ Immune Thrombocytopenia (ITP) (Proceed to Q27)
☐ Systemic Lupus Erythematous (Proceed to Q28)	

24. For ANCA Associated Vasculitis
Please choose *ALL* of the following that apply (Proceed to Q29)
☐ Member achieved disease control with induction treatment
☐ Member previously received a course of therapy and at least 16 weeks will elapse between courses

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25. For Pemphigus Vulgaris
Will the subsequent infusions be administered no sooner than 16 weeks following the previous infusion of a rituximab product? (Proceed to Q29)
☐ Yes
☐ No

26. For Rheumatoid Arthritis
Please choose *ALL* of the following that apply (Proceed to Q29)
☐ 16 weeks or greater will elapse between treatment courses
☐ If the member has already received two or more courses of therapy, the member has responded to therapy

27. For Immune Thrombocytopenia
Please choose *ALL* of the following that apply: (Proceed to Q29)
☐ At least 6 months will elapse between treatment courses.
☐ Member responded to therapy as shown by an increase in platelet count after treatment
☐ Member has relapsed as shown by thrombocytopenia after achievement of remission

28. For Systemic Lupus Erythematous
Will 6 months or greater elapse between treatment courses? (Proceed to Q29)
☐ Yes
☐ No

29. HCPCS Codes
Please document the applicable HCPCS codes (e.g. J codes or Q codes) being requested, including the number of units and number of visits *(using the space below):*
☐ HCPCS / Qcodes:
☐ Number of units:
☐ Number of visits:

Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form. Providers may attach any additional data relevant to medical necessity criteria.