# MEDICARE FORM

## Riabni® (rituximab-arrx), Rituxan® (rituximab), Ruxience (rituximab-pvvr), Truxima (rituximab-abbs) Medication Precertification Request



(All fields must be completed and legible for precertification review.)

**For Medicare Advantage Part B:**
**For other lines of business:**
Please use commercial form.

**Note: Riabni and Rituxan are non-preferred. The preferred biosimilar products are Ruxience and Truxima. For rheumatoid arthritis, all Rituxan and biosimilar products are non-preferred.**

Would you like to use electronic prior authorization? Consider using **Availity**, our electronic prior authorization portal. Learn more about **Availity** from the links in the table below.

For phone or fax requests, refer to the table below for routing information. To determine which box to use, refer to the patient's Aetna ID card. State specific special needs and Medicare-Medicaid Plans may be designated on the front of the ID card or in the website URL on the back of the card. If you don't see your specific plan listed, call the number on the back of the member's ID card to confirm routing information.

| |
|---|
| For **Aetna Medicare Advantage** and **Allina Health Aetna Medicare** members send request to:<br>**Phone:** 1-866-503-0857 **(TTY:** 711**)**<br>**Fax:** 1-844-268-7263<br>**Availity:** https://www.aetna.com/health-care-professionals/resource-center/availity.html |
| For Aetna Medicare Advantage **Virginia Dual Eligible Special Needs Plans** (HMO D-SNP) send request to:<br>**Phone:** 1-855-463-0933<br>**Fax:** 1-833-280-5224<br>**Availity:** https://www.aetnabetterhealth.com/virginia-hmosnp/providers/portal |
| For Aetna Assure Premier Plus Medicare Advantage **New Jersey Dual Eligible Special Needs Plans** (HMO D-SNP) send request to:<br>**Phone:** 1-844-362-0934<br>**Fax:** 1-833-322-0034<br>**Availity:** https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/portal.html |
| For Aetna Better Health of **Illinois Premier Medicare Medicaid Plan** (MMP) send request to:<br>**Phone:** 1-866-600-2139<br>**FAX:** 1-855-320-8445<br>**Availity:** https://www.aetnabetterhealth.com/illinois/providers/portal |
| For Aetna Better Health of **Ohio Premier Medicare Medicaid Plan** (MMP) send request to:<br>**Phone:** 1-855-364-0974<br>**Fax:** 1-855-734-9389<br>**Availity:** https://www.aetnabetterhealth.com/ohio/providers/portal |
| For Aetna Better Health of **Michigan Premier Medicare Medicaid Plan** (MMP) send request to:<br>**Phone:** 1-855-676-5772<br>**Fax:** 1-844-241-2495<br>**Availity:** https://www.aetnabetterhealth.com/michigan/providers/portal.html |

aetna®

# MEDICARE FORM
## Riabni® (rituximab-arrx), Rituxan® (rituximab), Ruxience (rituximab-pvvr), Truxima (rituximab-abbs) Medication Precertification Request



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

**For Medicare Advantage Part B:**
**For other lines of business:**
Please use commercial form.

**Note: Riabni and Rituxan are non-preferred. The preferred biosimilar products are Ruxience and Truxima. For rheumatoid arthritis, all Rituxan and biosimilar products are non-preferred.**

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: | | | DOB: |
| Address: | | City: | State: | ZIP: |
| Home Phone: | Work Phone: | Cell Phone: | E-mail: | |
| Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms | | Allergies: | | |

### B. INSURANCE INFORMATION

**Member ID #**: _____
**Group #**: _____
**Insured**: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

### C. PRESCRIBER INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| First Name: | | Last Name: | *(Check one):* ☑ M.D. ☐ D.O. ☐ N.P. ☐ P.A. | | |
| Address: | | | City: | State: | ZIP: |
| Phone: | Fax: | St Lic #: | NPI #: | DEA #: | UPIN: |
| Provider Email: | | Office Contact Name: | | Phone: | |

### D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

**Place of Administration:**
☐ Self-administered ☐ Physician's Office ☐ Home
☐ Outpatient Infusion Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
**TIN:** _____ PIN: _____
NPI: _____

**Dispensing Provider/Pharmacy:**
☐ *Outpatient Dialysis Center* ☐ Physician's Office
☐ Retail Pharmacy ☐ Specialty Pharmacy
☐ Mail Order ☐ Other: _____
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
**TIN:** _____ PIN: _____
NPI: _____

### E. PRODUCT INFORMATION

**Request is for:** ☐ **Riabni (rituximab-arrx)** ☐ **Rituxan (rituximab)** ☐ **Ruxience (rituximab-pvvr)** ☐ **Truxima (rituximab-abbs)**

**Dose:** _____ **Directions for Use:** _____ **HCPCS Code:** _____

### 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 Initiation Requests (clinical documentation required for all requests):**

**Note: Riabni and Rituxan are non-preferred. Ruxience and Truxima are the preferred biosimilars for most indications.**
**For rheumatoid arthritis, all Rituxan and biosimilar products are non-preferred. Inflectra, Renflexis and Simponi Aria are preferred for MA plans.**
**Enbrel, Humira, Idacio, Rinvoq, Tyenne SC and Xeljanz/Xeljanz XR are preferred for MAPD plans.**

☐ Yes ☐ No Has the patient had prior therapy with the requested product within the last 365 days?

☐ No Has the patient had a trial and failure of any of the following rituximab biosimilars? (If yes, select all that apply)
- ☐ Ruxience (rituximab-pvvr) ☐ Truxima (rituximab-abbs)
- When was the member's trial and failure of the preferred drug? _____
- Please describe the nature of the failure of the preferred drug _____

☐ No Has the patient had an adverse reaction to any of the following rituximab biosimilars? (If yes, select all that apply)
- ☐ Ruxience (rituximab-pvvr) ☐ Truxima (rituximab-abbs)
- When was the member's adverse reaction to the preferred drug? _____
- Please describe the nature of the adverse reaction to the preferred drug _____

Please explain if there are any contraindications or other medical reason(s) that the patient cannot use any of the following preferred biosimilar products when indicated for the patient's diagnosis? (select all that apply)
☐ Ruxience (rituximab-pvvr) ☐ Truxima (rituximab-abbs)

_____

***Continued on next page***

aetna®

# MEDICARE FORM
## Riabni® (rituximab-arrx), Rituxan® (rituximab), Ruxience (rituximab-pvvr), Truxima (rituximab-abbs) Medication Precertification Request



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

**For Medicare Advantage Part B:**
**For other lines of business:**
Please use commercial form.

**Note: Riabni and Rituxan are non-preferred. The preferred biosimilar products are Ruxience and Truxima. For rheumatoid arthritis, all Rituxan and biosimilar products are non-preferred.**

| Patient First Name | Patient Last Name | Patient Phone | Patient DOB |
|---|---|---|---|
| | | | |

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

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

☐ No Has the patient had a trial and failure of any of the following? (If yes, select all that apply)
☐ Inflectra (infliximab-dyyb) ☐ Renflexis (infliximab-abda) ☐ Simponi Aria (golimumab)
→ When was the member's trial and failure of the preferred drug? _____
→ Please describe the nature of the failure of the preferred drug _____

☐ No Has the patient had an adverse reaction to any of the following? (If yes, select all that apply)
☐ Inflectra (infliximab-dyyb) ☐ Renflexis (infliximab-abda) ☐ Simponi Aria (golimumab)
→ When was the member's adverse reaction to the preferred drug? _____
→ Please describe the nature of the adverse reaction to the preferred drug _____

☐ No Has the patient had a trial and failure of any of the following? (If yes, select all that apply)
☐ Enbrel (etanercept) ☐ Humira (adalimumab) ☐ Idacio (adalimumab-aacf) ☐ Rinvoq (upadacitinib) ☐ Tyenne SC (tocilizumab-aazg)
☐ Xeljanz/Xeljanz XR (tofacitinib)
→ When was the member's trial and failure of the preferred drug? _____
→ Please describe the nature of the failure of the preferred drug _____

☐ No Has the patient had a trial and failure of any of the following? (If yes, select all that apply)
☐ Enbrel (etanercept) ☐ Humira (adalimumab) ☐ Idacio (adalimumab-aacf) ☐ Rinvoq (upadacitinib) ☐ Tyenne SC (tocilizumab-aazg)
☐ Xeljanz/Xeljanz XR (tofacitinib)
→ When was the member's adverse reaction to the preferred drug? _____
→ Please describe the nature of the adverse reaction to the preferred drug _____

Please explain if there are any contraindications or other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis? (select all that apply)
☐ Inflectra (infliximab-dyyb) ☐ Renflexis (infliximab-abda) ☐ Simponi Aria (golimumab)

_____

Please explain if there are contraindications or any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis? (select all that apply)
☐ Enbrel (etanercept) ☐ Humira (adalimumab) ☐ Idacio (adalimumab-aacf) ☐ Rinvoq (upadacitinib) ☐ Tyenne SC (tocilizumab-aazg)
☐ Xeljanz/Xeljanz XR (tofacitinib)

_____

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

☐ Yes ☐ No Will Rituxan (rituximab) be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, infliximab)?

**Acute lymphoid leukemia**

☐ Yes ☐ No Does the patient have a documented diagnosis of Philadelphia chromosome-negative acute lymphoid leukemia (ALL)?
☐ Yes ☐ No Is Rituxan (rituximab) being used as induction/consolidation therapy?

**Autoimmune hemolytic anemia**

☐ Yes ☐ No Does the patient have a documented diagnosis of refractory autoimmune hemolytic anemia?

**Anti-neutrophil cytoplasmic antibody-associated (ANCA-associated) vasculitides**

Please indicate which of the following applies to the patient: ☐ Wegener granulomatosis ☐ Churg-Strauss syndrome ☐ microscopic polyangiitis ☐ pauci-immune glomerulonephritis

☐ Yes ☐ No Will Rituxan (rituximab) be given in conjunction with glucocorticoids?

**Autoimmune blistering diseases, corticosteroid-refractory**

☐ Yes ☐ No Does the patient have a documented diagnosis of corticosteroid-refractory autoimmune blistering disease?
→ Please select which applies to the patient: ☐ pemphigus vulgaris ☐ pemphigus folliaceus ☐ bullous pemphigoid ☐ cicatricial pemphigoid ☐ epidermolysis bullosa acquisita ☐ paraneoplastic pemphigus ☐ None of the above

**B-cell lymphomas**

Please select which applies to the patient: ☐ AIDS-related B-cell lymphoma ☐ Burkitt lymphoma ☐ Diffuse large B-cell lymphoma ☐ Follicular lymphoma ☐ Gastric MALT lymphoma ☐ High-grade B-Cell lymphoma ☐ Mantle cell lymphoma ☐ Nodal marginal zone lymphoma ☐ Nongastric MALT lymphoma ☐ Primary cutaneous B-cell lymphomas ☐ Splenic marginal zone lymphoma ☐ Other: _____

***Continued on next page***

# MEDICARE FORM
# Riabni® (rituximab-arrx), Rituxan® (rituximab), Ruxience (rituximab-pvvr), Truxima (rituximab-abbs) Medication Precertification Request



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

**For Medicare Advantage Part B:**
**For other lines of business:**
Please use commercial form.

**Note: Riabni and Rituxan are non-preferred. The preferred biosimilar products are Ruxience and Truxima. For rheumatoid arthritis, all Rituxan and biosimilar products are non-preferred.**

| Patient First Name | Patient Last Name | Patient Phone | Patient DOB |
|---|---|---|---|
| | | | |

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

**Castleman's disease**
☐ Yes ☐ No Does the patient have a documented diagnosis of multicentric Castleman's disease (angiofollicular lymph node hyperplasia)?

**Central nervous system lymphomas**
Please select which applies to the patient: ☐ leptomeningeal metastases from lymphoma ☐ primary CNS lymphoma ☐ none of the above

**Chronic or small lymphocytic leukemia**
Please select which applies to the patient: ☐ chronic lymphocytic leukemia (CLL) ☐ small lymphocytic leukemia ☐ none of the above

**Cryoglobulinemia**
☐ Yes ☐ No Does the patient have a documented diagnosis of cryoglobulinemia?
☐ Yes ☐ No Is there clinical documentation that the treatment with corticosteroids and other immunosuppressive agents was ineffective?

**Graft versus host disease, chronic**
☐ Yes ☐ No Is there a documentation that Rituxan (rituximab) being used as last-resort treatment for chronic graft versus host disease (GVHD)?

**Hairy cell leukemia**
Please select which applies to the patient: ☐ relapsed hairy cell leukemia ☐ refractory hairy cell leukemia ☐ none of the above

**Heart and solid organ transplant**
☐ Yes ☐ No Is there a documentation that Rituxan (rituximab) is being used for treatment or prevention (desensitization) of highly sensitized patients with antibody mediated rejection in heart transplant recipients and other solid organ transplant recipients?
→ Please select which applies to the patient: ☐ heart transplant recipient ☐ other solid organ transplant recipient

**Immune checkpoint-inhibitor related encephalitis**
Please identify which immune check-point inhibitor caused the encephalitis: ☐ Bavencio (avelumab) ☐ Imfinzi (durvalumab) ☐ Keytruda (pembrolizumab) ☐ Opdivo (nivolumab) ☐ Tecentriq (atezolizumab) ☐ Yervoy (ipilimumab) ☐ Other: _____

**Immune or idiopathic thrombocytopenic purpura**
☐ Yes ☐ No Does the patient have a documented diagnosis of refractory immune or idiopathic thrombocytopenic purpura (ITP)?
→ ☐ refractory immune thrombocytopenic purpura ☐ idiopathic thrombocytopenic purpura (ITP)

**Kidney transplant, rejection prophylaxis**
☐ Yes ☐ No Is Rituxan (rituximab) being used as rejection prophylaxis in sensitized kidney transplant recipients with donor specific antibodies?

**Lymphocyte-predominant Hodgkin's lymphoma**
☐ Yes ☐ No Does the patient have a documented diagnosis of lymphocyte-predominant Hodgkin's lymphoma?

**Multiple Sclerosis**
Please indicate the type of multiple sclerosis the patient has been diagnosed with:
☐ Relapsing-remitting MS (RRMS) ☐ Secondary-progressive MS (SPMS) ☐ Primary-progressive MS (PPMS) ☐ Progressive-relapsing MS (PRMS)
☐ Yes ☐ No Has the patient discontinued other medications used for treating MS (not including Ampyra)?

**Myasthenia gravis (MuSk-MG)**
☐ Yes ☐ No Does the patient have a documented diagnosis of muscle-specific tyrosine kinase myasthenia gravis (MuSK-MG)?
→ ☐ Yes ☐ No Has the patient had an unsatisfactory response to initial immunotherapy?

**Neuromyelitis optica (Devic's disease)**
☐ Yes ☐ No Does the patient have a documented diagnosis of neuromyelitis optica (Devic's disease)?
☐ Yes ☐ No Was the treatment with at least one immunotherapy ineffective?

**Opsoclonus-myoclonus-ataxia (opsoclonus myoclonus syndrome)**
☐ Yes ☐ No Does the patient have a documented diagnosis of opsoclonus-myoclonus-ataxia (OMA) associated with neuroblastoma?
☐ Yes ☐ No Is the patient refractory to steroids, chemotherapy and intravenous immunoglobulins?
→ Please provide the names and date ranges of medications tried:
Medication: _____ Dates: __/__/__ - __/__/__
Medication: _____ Dates: __/__/__ - __/__/__

**Post-transplant lymphoproliferative disorder**
☐ Yes ☐ No Is Rituxan (rituximab) being used as treatment of post-transplant lymphoproliferative disorder?
→ ☐ Yes ☐ No Is Rituxan (rituximab) being used as prophylaxis for Epstein-Barr virus (EBV) post-transplant lymphoproliferative disorder?

***Continued on next page***

# MEDICARE FORM
# Riabni® (rituximab-arrx), Rituxan® (rituximab), Ruxience (rituximab-pvvr), Truxima (rituximab-abbs) Medication Precertification Request



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

**For Medicare Advantage Part B:**
**For other lines of business:**
Please use commercial form.

**Note: Riabni and Rituxan are non-preferred. The preferred biosimilar products are Ruxience and Truxima. For rheumatoid arthritis, all Rituxan and biosimilar products are non-preferred.**

| Patient First Name | Patient Last Name | Patient Phone | Patient DOB |
|---|---|---|---|
| | | | |

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

**Rheumatoid Arthritis**

Please indicate the severity of the patient's rheumatoid arthritis: ☐ Mild ☐ Moderate ☐ Severe

☐ Yes ☐ No Is there evidence that the disease is active?

☐ Yes ☐ No Will Rituxan (rituximab) be used in combination with methotrexate?

→ ☐ Yes ☐ No Was treatment with methotrexate ineffective, not tolerated or contraindicated?

→ Please select: ☐ ineffective ☐ not tolerated ☐ contraindicated

☐ Yes ☐ No Was treatment with another conventional DMARD ineffective?

→ Please select: ☐ azathioprine ☐ cyclosporine ☐ hydroxychloroquine ☐ leflunomide ☐ sulfasalazine

**Sjögren syndrome**

☐ Yes ☐ No Does the patient have a documented diagnosis of Sjögren's syndrome?

☐ Yes ☐ No Was treatment with corticosteroids and other immunosuppressive agents ineffective?

→ Please provide the names and dates of the corticosteroids and other immunosuppressive agents used:

Medication: _____ Dates: ___/___/___ - ___/___/___

Medication: _____ Dates: ___/___/___ - ___/___/___

**Thrombotic thrombocytopenic purpura**

☐ Yes ☐ No Does the patient have a documented diagnosis of refractory thrombotic thrombocytopenic purpura (TTP)?

**Waldenstrom's macroglobulinemia**

☐ Yes ☐ No Does the patient have a documented diagnosis of Waldenström macroglobulinemia?

**For Continuation Requests:**

☐ Yes ☐ No Is this continuation request a result of the patient receiving samples of Rituxan (rituximab)?

Please indicate the length of time on Rituxan (rituximab): _____

**For rheumatoid arthritis only:**

Please indicate the severity of the disease at baseline (pretreatment with Rituxan (rituximab): ☐ Mild ☐ Moderate ☐ Severe

☐ Yes ☐ No Is there clinical documentation supporting disease stability?

☐ Yes ☐ No Is there clinical documentation supporting disease improvement?

**For all other indications:**

☐ Yes ☐ No Is there clinical documentation supporting disease stability?

☐ Yes ☐ No Is there clinical documentation supporting disease improvement?

**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.