# Rituxan, Ruxience, Truxima

## Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

**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* ❑ *Home* ❑ *Inpatient Hospital* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

**Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720**

**Criteria Questions:**

1. What is the prescribed product? ❑ Rituxan ❑ Ruxience ❑ Truxima

2. What is the diagnosis?

***Non-Oncology***

- ❑ Moderately to severely active rheumatoid arthritis
- ❑ Relapsing-remitting multiple sclerosis (RRMS)
- ❑ Granulomatosis with polyangiitis (GPA) (Wegener's granulomatosis)
- ❑ Microscopic polyangiitis (MPA)
- ❑ Churg-Strauss syndrome
- ❑ Pauciimune glomerulonephritis
- ❑ Sjögren's syndrome
- ❑ Immune or Idiopathic thrombocytopenic purpura (ITP), refractory
- ❑ Autoimmune hemolytic anemia
- ❑ Thrombotic thrombocytopenic purpura (TTP)
- ❑ Myasthenia gravis, refractory
- ❑ Chronic graft versus host disease
- ❑ Prevention of Epstein-Barr virus (EBV) related post-transplant lymphoproliferative disorder (PTLD)
- ❑ Neuromyelitis optica (Devic disease)
- ❑ Autoimmune blistering disease (e.g., pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, cicatricial pemphigoid, epidermolysis bullosa acquisita and paraneoplastic pemphigus)
- ❑ Cryoglobulinemia
- ❑ Solid organ transplant and prevention of antibody mediated rejection in solid organ transplant
- ❑ Opsoclonus-myoclonus ataxia
- ❑ Systemic lupus erythematosus
- ❑ Immune Checkpoint Inhibitor-related toxicities

***Oncology***

- ❑ Diffuse large B-cell lymphoma (DLBCL), CD20 positive
- ❑ High-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 (double/triple hit lymphoma), CD20 positive
- ❑ High-grade B-cell lymphoma, not otherwise specified, CD20 positive
- ❑ Chronic lymphocytic leukemia (CLL), CD20 positive
- ❑ Small lymphocytic lymphoma (SLL), CD20 positive
- ❑ Follicular lymphoma, CD20 positive
- ❑ Mantle cell lymphoma, CD20 positive
- ❑ Marginal zone lymphoma (nodal, splenic or gastric/non-gastric mucosa-associated lymphoid tissue [MALT] lymphoma), CD20 positive
- ❑ Burkitt lymphoma, CD20 positive
- ❑ Castleman's disease, CD20 positive
- ❑ Acquired immunodeficiency syndrome (AIDS-)-related B-cell lymphoma, CD20 positive
- ❑ Primary cutaneous B-cell lymphoma, CD20 positive
- ❑ Hairy cell leukemia, CD20 positive
- ❑ Post-transplant lymphoproliferative disorder (PTLD), CD 20 positive
- ❑ Histological transformation from follicular lymphoma to diffuse large B-cell lymphoma, CD20 positive
- ❑ Histological transformation from nodal marginal zone lymphoma to diffuse large B-cell lymphoma, CD20 positive
- ❑ B-cell lymphoblastic lymphoma, CD20 positive
- ❑ Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma (LPL), CD20 positive
- ❑ Hodgkin's lymphoma, nodular lymphocyte-predominant, CD20 positive
- ❑ Primary central nervous system (CNS) lymphoma, CD20 positive
- ❑ Leptomeningeal metastases from lymphomas, CD20 positive
- ❑ B-cell acute lymphoblastic leukemia (ALL), CD20 positive
- ❑ Other _____

3. What is the ICD-10 code?
***If diagnosis is RA, MS, SLE or any oncologic indications, skip to diagnosis section.***

4. Is this a request for continuation of therapy with the requested drug?
❑ Yes ❑ No *If No, skip to diagnosis section.*

5. Is the patient experiencing benefit from therapy? ❑ Yes ❑ No

***Complete the following section(s) based on the patient's diagnosis, if applicable.***

Section A: Rheumatoid Arthritis

6. Has the patient previously received a biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) that is indicated for moderately to severely active rheumatoid arthritis? *If Yes, skip to #9* ❑ Yes ❑ No

7. Has the patient received two full doses of the requested medication, with the most recent dose being within 6 months of this request? *If Yes, skip to #9* ❑ Yes ❑ No

8. 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 *If No, skip to #10*

9. Is the requested drug being prescribed in combination with methotrexate? *If Yes, skip to #13* ❑ Yes ❑ No

10. Has the patient experienced intolerance to methotrexate? *If Yes, skip to #12* ❑ Yes ❑ No

11. Does the patient have a contraindication to methotrexate? ❑ Yes ❑ No
***If Yes, indicate contraindication: _____***

12. Has the patient experienced an inadequate response with another conventional DMARD (e.g., hydroxychloroquine, leflunomide, sulfasalazine)? ❑ Yes ❑ No

13. Will the requested drug be used with another biologic for the treatment of rheumatoid arthritis? ❑ Yes ❑ No

14. Is the planned date of administration at least 16 weeks after the date of the last dose received?
❑ Yes ❑ No ❑ Not applicable - Patient has not received any previous dose

15. Is this request for continuation of therapy? ❑ Yes ❑ No *If No, no further questions.*

16. How many doses in total has the patient received since starting treatment with the requested medication?
_____

17. *If two or more doses,* has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of rheumatoid arthritis since starting treatment with the requested medication? ❑ Yes ❑ No

Section B: Multiple Sclerosis

18. Is the patient taking the requested medication with any other medication used for the treatment of multiple sclerosis other than Ampyra? ❑ Yes ❑ No

19. Is this a request for continuation of therapy? ❑ Yes ❑ No *If No, no further questions.*

20. Is the patient experiencing disease stability or improvement while receiving the requested medication?
❑ Yes ❑ No

Section C: Oncologic Indications

21. Is this a request for continuation of therapy with the requested drug? *If Yes, skip to #23* ❑ Yes ❑ No

22. 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.*** ❑ Yes ❑ No ❑ Unknown *No further questions*

23. Is there evience of unacceptable toxicity on the current regimen? ❑ Yes ❑ No

Section D: Systemic Lupus Erythematosus

24. Is the disease refractory to immunosuppressive therapy? ❑ Yes ❑ No

25. Is this a request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, no further questions*

26. Is the patient experiencing benefit from therapy? ❑ Yes ❑ No

Section E: Sjogren's Syndrome or Cryoglobulinemia

27. Have corticosteroids and other immunosuppressive agents been ineffective? ❑ Yes ❑ No

Section F: Neuromyelitis Optica

28. Has at least one other immunotherapy agent been ineffective? ❑ Yes ❑ No

Section G: Autoimmune Blistering Disease (e.g., Pemphigus Vulgaris, Pemphigus Foliaceus, Bullous Pemphigoid, Cicatricial Pemphigoid, Epidermolysis Bullosa Acquisita and Paraneoplastic Pemphigus)

29. Is the disease corticosteroid refractory? ❑ Yes ❑ No

Section H: Solid Organ Transplant

30. Is the requested drug being used for the prevention of antibody mediated rejection in solid organ transplant? ❑ Yes ❑ No

Section I: Opsoclonus-Myoclonus-Ataxia

31. Is the requested drug being used for opsoclonus-myoclonus ataxia associated with neuroblastoma? ❑ Yes ❑ No

32. Is the patient refractory to steroids and chemotherapy? ❑ Yes ❑ No

***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)**

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