Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Riabni, Rituxan, Ruxience, Truxima (rituximab)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed**		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested: ☐ Riabni ☐ Rituxan ☐ Ruxience ☐ Truxima

Dose: Frequency of therapy: Duration of therapy:

Is this a new start or continuation of therapy***? ☐ new start of therapy ☐ continued therapy – start date:
****If your patient has already begun treatment with drug samples of this drug, please choose "new start of therapy".*

ICD10:

Will this medication be given concurrently with other agents? ☐ Yes ☐ No If yes, please specify:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use (please specify):

Oncology Diagnoses:

- ☐ acute lymphoblastic leukemia (ALL)
- ☐ AIDS-related B-cell lymphoma
- ☐ B-cell lymphoblastic lymphoma (B-LBL)
- ☐ B-cell non-Hodgkin lymphoma (B-cell NHL-NOT CD20 Positive)
- ☐ Burkitt lymphoma
- ☐ CD20-positive B-cell non-Hodgkin's lymphoma (CD20-NHL)
- ☐ CD20-positive Chronic Lymphocytic Leukemia (CD20-CLL)
- ☐ Castleman's disease (CD, giant lymph node hyperplasia, angiofollicular lymph node hyperplasia)
- ☐ Central nervous system cancers {that is, leptomeningeal metastases [intracerebrospinal fluid (CSF) treatment]; primary central nervous system lymphoma}
- ☐ chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)
- ☐ diffuse large B-cell lymphoma (DLBCL)
- ☐ follicular lymphoma (FL)
- ☐ gastric MALT lymphoma
- ☐ hairy cell leukemia
- ☐ high grade B-cell lymphoma
- ☐ histologic transformation of indolent lymphoma to diffuse large B-cell lymphoma (DLBCL)
- ☐ histological transformation from nodal marginal zone lymphoma (NMZL) to diffuse large B-cell lymphoma (DLBCL)
- ☐ Hodgkin lymphoma (HL) (including lymphocyte-predominant Hodgkin lymphoma/LPHL)
- ☐ low grade B-cell lymphoma
- ☐ mantle cell lymphoma (MCL)
- ☐ nongastric MALT lymphoma
- ☐ nodal marginal zone lymphoma (NMZL) [also known as monocytoid B-cell lymphoma]
- ☐ post-transplant lymphoproliferative disorder (PTLD)
- ☐ primary cutaneous B-cell lymphoma (CBCL)
- ☐ splenic marginal zone lymphoma (SMZL)
- ☐ Waldenstrom's Macroglobulinemia (WM, lymphoplasmacytic lymphoma)
- ☐ other cancer diagnosis not listed above

Non-oncology diagnoses:

- ☐ Antineutrophil Cytoplasmic Antibody (ANCA)-associated vasculitis (AAV)
- ☐ Graft Versus Host Disease (GvHD)
- ☐ Factor Inhibitors in an Individual with Hemophilia
- ☐ immune or idiopathic thrombocytopenia (ITP)
- ☐ Immunotherapy-Related Toxicities Associated with Checkpoint Inhibitors
- ☐ Membranous Nephropathy/Membranous Glomerular Nephropathy
- ☐ Multiple Sclerosis (MS)
- ☐ Myasthenia Gravis (MG)
- ☐ neuromyelitis optica Spectrum Disorder (NMO, Devic's disease)
- ☐ Pediatric Acute-Onset Neuropsychiatric Syndrome/Pediatric Autoimmune Neuropsychiatric Disorders (PANS/PANDAS)
- ☐ pediatric nephrotic syndrome (PNS)
- ☐ pemphigus vulgaris or other autoimmune blistering disease (for example, pemphigus foliaceus, bullous pemphigoid, cicatricial pemphigoid, epidermolysis bullosa acquisita, and paraneoplastic pemphigus)
- ☐ Refractory Autoimmune Hemolytic Anemia
- ☐ Rheumatoid arthritis (RA)
- ☐ solid organ transplant
- ☐ systemic lupus erythematous (SLE) (Lupus, Nephrotic Syndrome with SLE)
- ☐ thrombotic thrombocytopenic purpura (TTP)
- ☐ other non-cancer diagnosis not listed above

(if other/unknown) What diagnosis is rituximab being used to treat?

Clinical Information:

FOR ALL DIAGNOSES (oncology and non-oncology)

(IF Rituxan, for initial therapy) Has your patient tried ALL of the following: Riabni (rituximab-arrx), Ruxience (rituximab-pvvr) AND Truxima (rituximab-abbs)? ☐ Yes ☐ No

(if yes) Please provide dates of treatment

(If Rituxan, new start) The covered alternatives are: Riabni (rituximab-arrx) [may require prior authorization], Ruxience (rituximab-pvvr) [may require prior authorization] and Truxima (rituximab-abbs) [may require prior authorization]. For the alternatives tried, please include medication name and strength, date(s) taken and for how long, and what the documented results were of taking each medication, including any intolerances or adverse reactions your patient experienced.

(If Rituxan, new start) For Riabni (rituximab-arrx), which of the following applies to your patient?

- ☐ Patient has not tried this medication
- ☐ Patient tried this medication, but it didn't work or didn't work well enough
- ☐ Patient tried this medication, but had an allergic or adverse reaction
- ☐ Other

Is there documentation that this reaction was due to a formulation difference in the inactive ingredients between the requested medication and Riabni (rituximab-arrx) (for example, difference in dyes, fillers, preservatives)? ☐ Yes ☐ No

(If Rituxan, new start) For Ruxience (rituximab-pvvr), which of the following applies to your patient?

- ☐ Patient has not tried this medication
- ☐ Patient tried this medication, but it didn't work or didn't work well enough
- ☐ Patient tried this medication, but had an allergic or adverse reaction
- ☐ Other

Is there documentation that this reaction was due to a formulation difference in the inactive ingredients between the requested medication and Ruxience (rituximab-pvvr) (for example, difference in dyes, fillers, preservatives)? ☐ Yes ☐ No

(If Rituxan, new start) For Truxima (rituximab-abbs), which of the following applies to your patient?

- ☐ Patient has not tried this medication
- ☐ Patient tried this medication, but it didn't work or didn't work well enough
- ☐ Patient tried this medication, but had an allergic or adverse reaction
- ☐ Other

Is there documentation that this reaction was due to a formulation difference in the inactive ingredients between the requested medication and Truxima (rituximab-abbs) (for example, difference in dyes, fillers, preservatives)? ☐ Yes ☐ No

(if yes) Please provide details about these reactions to support.

****For diagnosis of Rheumatoid Arthritis (RA)****Is this for new start of therapy or continuation of therapy?

- ☐ new Start
- ☐ continuation of therapy

(if RA) Will this medication be used for Initial Therapy or has the patient already received a course of a rituximab product for RA?

- ☐ Initial Therapy
- ☐ Already received rituximab

(if RA) Will this medication be used in combination with methotrexate? ☐ Yes ☐ No

(if no) Why won't the patient take this medication with methotrexate?

- ☐ The patient tried methotrexate, but it didn’t work.
- ☐ The patient tried methotrexate, but they did not tolerate it
- ☐ The patient cannot try methotrexate because of a contraindication to it.
- ☐ Other

(if RA) Besides the medication being requested, other biologics and tsDMARDs (targeted synthetic disease-modifying antirheumatic drugs) include Actemra, adalimumab (Humira and all biosimilars) Adbry, Bimzelx, Cibinqo, Cimzia, Cosentyx, Enbrel, Entyvio, Ilumya, Infliximab (Remicade and all biosimilars) Kevzara, Kineret, Litfulo, Olumiant, Omvoh, Orencia, Otezla, Rinvoq, rituximab (Rituxan and all biosimilars), Siliq, Simponi Aria, Simponi, Skyrizi, Sotyktu, Stelara, Taltz, Tremfya, Tysabri, Velsipity, Xeljanz/Xeljanz XR, and Zeposia. Which of the following best describes your patient's situation?

☐ The patient is NOT taking any other biologic or tsDMARD at this time, nor will they in the future. The requested drug is the only biologic or tsDMARD the patient is/will be using.

☐ The patient is currently on another biologic or tsDMARD, but this drug will be stopped and the requested drug will be started.

☐ The patient is currently on another biologic or tsDMARD, and the requested drug will be added. The patient may continue to take both drugs together.

☐ The patient is currently on BOTH the requested drug AND another biologic or tsDMARD.

☐ Other

(if RA) Is this medication being prescribed by, or in consultation with, a rheumatologist? ☐ Yes ☐ No

(if RA) How many courses of a rituximab product has your patient received for rheumatoid arthritis? courses of a rituximab

(if RA, already received rituximab) Will there be a minimum of 16 weeks since the first dose of the previous course and the first dose of the next course of a rituximab product? ☐ Yes ☐ No

(if RA, already received rituximab) Has your patient had a beneficial response to rituximab [Note: Examples of a beneficial response include: less joint pain or morning stiffness; improved function or activities of daily living; decreased soft tissue swelling in joints or tendon sheaths; improved laboratory values (for example, CRP, ESR, anemia); reduced dosage of corticosteroids]? ☐ Yes ☐ No

(if no) Please provide support for continued use in your patient.

(if RA) Has your patient already tried a 3-month trial of at least one biologic or tsDMARDs (targeted synthetic disease-modifying antirheumatic drugs) such as Actemra, adalimumab (adalimumab-ADAZ, adalimumab-FKJP, Amjevita, Cyltezo, Hadlima, Hulio, Humira, Hyrimoz, Idacio, Yuflyma, Yusimry), Adbry, Cibinqo, Cimzia, Cosentyx, Enbrel, Entyvio, Ilumya, Infliximab (Avsola, Inflectra, Remicade, Renflexis), Kevzara, Kineret, Olumiant, Orencia, Otezla, Rinvoq, rituximab (Riabni, Rituxan, Rituxan Hycela, Ruxience, Truxima), Siliq, Simponi Aria, Simponi, Skyrizi, Sotyktu, Stelara, Taltz, Tremfya, Tysabri, Xeljanz/Xeljanz XR, and Zeposia? ☐ Yes ☐ No

(if RA and no 3-month trial of biologic or tsDMARD) The covered alternative is a minimum 3 month trial of one conventional synthetic disease-modifying antirheumatic drug (DMARD) (for example: methotrexate, leflunomide, sulfasalazine). For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced. For the alternatives NOT tried, please provide details why your patient can't try that drug.

(if RA and no 3-month trial of biologic or tsDMARD) Per the information provided above, which of the following is true for your patient in regards to the covered alternative?

☐ The patient tried one of the alternatives for at least 3 months, but it didn't work.

☐ The patient tried ALL of these alternatives, but did not tolerate any of them.

☐ The patient can't try ANY of these alternatives because of a contraindication to all of them.

☐ Other

(if RA) Will your patient be taking the requested medication at the same time as Enspryng (satralizumab-mwge subcutaneous injection), Soliris (eculizumab injection), Ultomiris (ravulizumab intravenous infusion), or Uplizna (inebilizumab-cdon intravenous infusion)? ☐ Yes ☐ No

(if RA) The covered alternative is a minimum 3 month trial of one anti-tumor necrosis factor (TNF) biologic therapy - Humira, Cimzia, Remicade, Simponi, or any of their biosimilars. For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced. For the alternatives NOT tried, please provide details why your patient can't try that drug.

(if RA) Per the information provided above, which of the following is true for your patient in regards to the covered alternative?

☐ The patient tried one of the alternatives for at least 3 months, but it didn't work.

☐ The patient tried ALL of these alternatives, but did not tolerate any of them.

☐ The patient can't try ANY of these alternatives because of a contraindication to anti-tumor necrosis factor (TNF) biologic therapy.

☐ Other

****For oncology diagnoses****
****This drug REQUIRES supportive documentation for ALL answers, including chart notes, lab/test results, etc. Supportive documentation for all answers must be attached to this request.****

Is this a new start or continuation of therapy with this medication? If your patient has already begun treatment with samples, please choose "new start of therapy".

☐ new start
☐ continuation of therapy

(If ALL) Does your patient have Philadelphia chromosome-negative (PH-) ALL? ☐ Yes ☐ No

(If Truxima/Ruxience/Riabni, if B-cell NHL-NOT CD20 Positive NHL) Is this this medication being used after first-line treatment with CVP (cyclophosphamide [Cytoxan], vincristine [Oncovin, Vincasar PFS], and prednisone) regimen? ☐ Yes ☐ No

(If Truxima/Ruxience/Riabni, if B-cell NHL-NOT CD20 Positive NHL) Does your patient have stable (not progressing) disease? ☐ Yes ☐ No

(If Truxima/Ruxience/Riabni, if B-cell NHL-NOT CD20 Positive NHL) Is the requested drug the ONLY one that will be used for the treatment of the diagnosis at this time? ☐ Yes ☐ No

(If CLL/SLL) Does your patient have relapsed or refractory disease? ☐ Yes ☐ No

(If CLL/SLL) Does your patient have the del(17p)/TP53 mutation? ☐ Yes ☐ No

(if Rituxan and CLL/SLL) Will this medication being used in combination with high-dose methylprednisolone (HDMP)? ☐ Yes ☐ No

(if in combo with HDMP AND less than 65 years old) Does your patient have significant comorbidities? ☐ Yes ☐ No

(If Truxima/Ruxience/Riabni, if CD20 positive NHL) Is the requested drug being used after first-line treatment with CVP (cyclophosphamide [Cytoxan], vincristine [Oncovin, Vincasar PFS], and prednisone) regimen? ☐ Yes ☐ No

(If Truxima/Ruxience/Riabni, if CD20 positive NHL) Is this drug the ONLY one that will be used for the treatment of the diagnosis at this time? ☐ Yes ☐ No

(If Truxima/Ruxience/Riabni, if CD20 positive NHL) Does your patient have stable (not progressing) disease? ☐ Yes ☐ No

(If Truxima/Ruxience/Riabni, if CD20 positive NHL and no CVP, or FL) Which best describes how the requested drug is being used for your patient?

☐ Maintenance therapy
☐ Therapy for relapsed or refractory disease
☐ Previously untreated disease
☐ None of the above

(If Maintenance therapy) Did your patient have a partial or complete response to first-line treatment with a rituximab product (Rituxan, Riabni, Ruxience, Truxima) in combo with other chemotherapy? ☐ Yes ☐ No

(if Therapy for relapsed or refractory disease OR Maintenance therapy) Is the requested drug the ONLY one that will be used for the treatment of the diagnosis at this time? ☐ Yes ☐ No

(if Previously untreated disease) Will the requested drug be used in combination with other chemotherapy? ☐ Yes ☐ No

(if Rituxan and for FL) Which of the following best describes the place in therapy of the requested medication?

☐ As maintenance therapy after achieving a complete or partial response to a rituximab product (Riabni, Rituxan, Rituxan Hycela, Ruxience, Truxima) in combination with chemotherapy
☐ In previously untreated disease
☐ For relapsed or refractory disease
☐ None of the above

(if Rituxan and maintenance therapy or relapsed/refractory FL) Is this medication being given as single agent therapy? ☐ Yes ☐ No

(if Rituxan and previously untreated FL) Will this medication be used in combination with chemotherapy? ☐ Yes ☐ No

(If Truxima/Ruxience/Riabni, if Low grade B-cell lymphoma) Which best describes how the requested drug is being used for your patient?

☐ Relapsed or refractory disease
☐ Received first-line treatment with CVP (cyclophosphamide [Cytoxan], vincristine [Oncovin, Vincasar PFS], and prednisone) regimen
☐ None of the above

(if relapsed or refractory disease) Is this drug the ONLY one that will be used for the treatment of the diagnosis at this time? ☐ Yes ☐ No

(if received first-line treatment with CVP) Does your patient have stable (not progressing) disease? ☐ Yes ☐ No

(if received first-line treatment with CVP) Is the requested drug the ONLY one that will be used for the treatment of the diagnosis at this time? ☐ Yes ☐ No

(If Truxima/Ruxience/Riabni and for Gastric MALT lymphoma, Nongastric MALT Lymphoma, NMZL, or SMZL) Is the requested drug being used to initiate treatment in this patient? ☐ Yes ☐ No

(if Rituxan and SMZL) Is this medication being used to initiate treatment? ☐ Yes ☐ No

(if oncology diagnosis) What other treatments is your patient receiving with rituximab? Please provide clinical support for the use of this drug in your patient (including disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently).

****For non-oncology diagnoses****
****This drug REQUIRES supportive documentation for ALL answers, including chart notes, lab/test results, etc. Supportive documentation for all answers must be attached to this request.****

Has the patient previously been started on, or is currently receiving this drug? If your patient has already begun treatment with drug samples, please choose "new start of therapy".
- ☐ NEW START of therapy
- ☐ CONTINUATION of therapy

For continued use, has your patient had a beneficial response? ☐ Yes ☐ No
(if no) Please provide support for continued use in your patient.

Will your patient be taking the requested medication at the same time as Enspryng (satralizumab-mwge subcutaneous injection), Soliris (eculizumab injection), Ultomiris (ravulizumab intravenous infusion), or Uplizna (inebilizumab-cdon intravenous infusion)? ☐ Yes ☐ No

(if AAV) Is rituximab being prescribed by, or in consultation with, a rheumatologist, nephrologist, or immunologist? ☐ Yes ☐ No

(if AAV) Will rituximab be used for induction treatment or follow-up treatment after induction treatment?
- ☐ induction treatment
- ☐ follow-up treatment after induction treatment

(if AAV, induction) Does the patient have an ANCA-associated vasculitis? [Note: Examples of ANCA-associated vasculitis include granulomatosis with polyangiitis (GPA) (Wegener's granulomatosis), Churg-Strauss syndrome, microscopic polyangiitis (MPA), or pauci-immune glomerulonephritis. ☐ Yes ☐ No

(if AAV, induction) Will rituximab be used with glucocorticoids? ☐ Yes ☐ No
(if AAV - if no) Why won't the patient take rituximab with glucocorticoids?
- ☐ The patient tried glucocorticoids, but it didn't work.
- ☐ The patient tried glucocorticoids, but they did not tolerate them.
- ☐ The patient cannot try glucocorticoids because of a contraindication to these drugs.
- ☐ Other

(if AAV, follow-up treatment) Has the patient achieved disease control with induction treatment? ☐ Yes ☐ No

(if AAV, follow-up treatment) Will at least 16 weeks elapse between courses of a rituximab product? ☐ Yes ☐ No

(if Pemphigus Vulgaris) Is this medication being prescribed by, or in consultation with, a dermatologist? ☐ Yes ☐ No

(if Pemphigus Vulgaris) Will rituximab be used for initial treatment or for relapse/maintenance?
- ☐ initial treatment
- ☐ relapse/maintenance

(if Pemphigus Vulgaris, initial) Will this medication be used with a systemic corticosteroid (for example, prednisone)? ☐ Yes ☐ No

(if Pemphigus Vulgaris, initial - if no) Why won't the patient take rituximab with a systemic corticosteroid (for example, prednisone)?
- ☐ The patient tried a systemic corticosteroid, but it didn't work.
- ☐ The patient tried systemic corticosteroids, but they did not tolerate them.
- ☐ The patient can't try a systemic corticosteroid because of a contraindication to these drugs.
- ☐ Other

(if Pemphigus Vulgaris, relapse/maintenance) Will subsequent infusions be administered no sooner than 16 weeks following the previous infusion of a rituximab product? ☐ Yes ☐ No

(if Graft-Versus-Host Disease) Is this medication being prescribed by, or in consultation with, an oncologist, hematologist, or a physician

affiliated with a transplant center? ☐ Yes ☐ No

(if Graft-Versus-Host Disease) The covered alternative is ONE conventional systemic treatment for graft-versus-host disease [for example, systemic corticosteroids (methylprednisolone, prednisone), cyclosporine, tacrolimus, mycophenolate mofetil, Imbruvica (ibrutinib capsules and tablets), imatinib, antithymocyte globulin, Nipent (pentostatin infusion), or an infliximab product]. If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

(if Graft-Versus-Host Disease) Per the information provided above, which of the following is true for your patient in regards to the covered alternative (conventional systemic treatments)?

- ☐ The patient tried one of the alternatives, but it didn't work.
- ☐ The patient tried one of the alternatives, but they did not tolerate it.
- ☐ The patient cannot try one of these alternatives because of a contraindication to this drug.
- ☐ other

(if ITP) Is this medication being prescribed by, or in consultation with, a hematologist? ☐ Yes ☐ No

(if ITP) Will rituximab be used for Initial Therapy or has the patient already received a course of a rituximab product for ITP?

- ☐ initial therapy
- ☐ already received rituximab

(if ITP, initial) The covered alternatives are: other therapy for ITP (for example, intravenous immunoglobulin (IVIG), anti-D (RHO) immunoglobulin, corticosteroids, or splenectomy). For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced. For the alternatives NOT tried, please provide details why your patient can't try that drug.

(if ITP, initial) Per the information provided above, which of the following is true for your patient in regards to the covered alternative (intravenous immunoglobulin (IVIG), anti-D (RHO) immunoglobulin, corticosteroids, or splenectomy)?

- ☐ The patient tried one of the alternatives, but it didn't work.
- ☐ The patient tried one of the alternatives, but they did not tolerate it.
- ☐ The patient cannot try one of these alternatives because of a contraindication to this drug.
- ☐ other

(if ITP, already received) Will at least 6 months elapse between treatment courses (for example, there will be a minimum of 6 months separating the first dose of the previous course and the first dose of the requested course of a rituximab product)? ☐ Yes ☐ No

(if ITP, already received) Has the patient responded to therapy with this drug (for example, a platelet count increase from baseline following treatment with a rituximab product)? ☐ Yes ☐ No

(if ITP, already received) Has the patient relapsed (for example, the individual experiences thrombocytopenia after achievement of a remission)? ☐ Yes ☐ No

(if hemophilia) Was your patient refractory to conventional treatments [for example, immune tolerance induction (ITI), steroids, cyclophosphamide]? ☐ Yes ☐ No

(if MS) The covered alternatives are: other disease-modifying agents for multiple sclerosis (for example, Aubagio, Avonex/Rebif, Bafiertam, Betaseron/Extavia, Copaxone/glatiramer/Glatopa, dimethyl fumarate/Tecfidera, Gilenya, Kesimpta, Lemtrada, Mavenclad, Mayzent, Ocrevus, Plegridy, Ponvory, Tysabri, Vumerity, and Zeposia). For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced. For the alternatives NOT tried, please provide details why your patient can't try that drug.

(if MS) Per the information provided above, which of the following is true for your patient in regards to the covered alternative (conventional systemic treatments)?

- ☐ The patient tried one of the alternatives, but it didn't work.
- ☐ The patient tried one of the alternatives, but they did not tolerate it.
- ☐ The patient cannot try one of these alternatives because of a contraindication to this drug.
- ☐ other

(if MS) Will rituximab be used concurrently with another disease-modifying agent used for multiple sclerosis (for example, Aubagio, Avonex/Rebif, Bafiertam, Betaseron/Extavia, Copaxone/glatiramer/Glatopa, dimethyl fumarate/Tecfidera, Gilenya, Kesimpta, Lemtrada, Mavenclad, Mayzent, Ocrevus, Plegridy, Ponvory, Tysabri, Vumerity, and Zeposia)? ☐ Yes ☐ No

(if MS) Will at least 6 months elapse between treatment courses (for example, there will be a minimum of 6 months separating the first dose of the previous course and the first dose of the requested course of a rituximab product)? ☐ Yes ☐ No

(if MS) Is this medication being prescribed by, or in consultation with, a physician who specializes in the treatment of multiple sclerosis and/or a neurologist? ☐ Yes ☐ No

(if NMO) Is this medication being prescribed by, or in consultation with, a neurologist? ☐ Yes ☐ No

(if SLE) Is this medication being prescribed by, or in consultation with, a rheumatologist, nephrologist, or neurologist? ☐ Yes ☐ No

(if SLE) Will rituximab be used for Initial Therapy or has the patient already received a course of a rituximab product for SLE?
- ☐ initial therapy
- ☐ already received rituximab.

(if SLE, initial) The covered alternatives are: standard immunomodulating or immunosuppressant agents [for example, hydroxychloroquine, corticosteroids (for example, prednisone, methylprednisolone), methotrexate, azathioprine, mycophenolate, or cyclophosphamide]). For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced. For the alternatives NOT tried, please provide details why your patient can't try that drug.

(if SLE, initial) Per the information provided above, which of the following is true for your patient in regards to the covered alternative (standard immunomodulating or immunosuppressant agent)?
- ☐ The patient tried one of the alternatives, but it didn't work.
- ☐ The patient tried one of the alternatives, but they did not tolerate it.
- ☐ The patient cannot try one of these alternatives because of a contraindication to this drug.
- ☐ other

(if SLE, already received) Will at least 6 months elapse between treatment courses (for example, there will be a minimum of 6 months separating the first dose of the previous course and the first dose of the requested course of a rituximab product)? ☐ Yes ☐ No

(if SLE, already received) Has the patient had a documented beneficial response to therapy [Examples of a beneficial response include: reduction in flares; reduction in corticosteroid dose; decrease of anti-dsDNA titer; improvement in specific organ dysfunction (for example, musculoskeletal, blood, hematologic, vascular, others]? ☐ Yes ☐ No

(if Membranous Nephropathy) Is this medication being prescribed by, or in consultation with, a nephrologist? ☐ Yes ☐ No
(if Membranous Nephropathy) Does the patient have either eGFR less than 60 ml/min or declining renal function not otherwise explained? ☐ Yes ☐ No

(if Membranous Nephropathy) Does the patient have nephrotic syndrome (nephrotic proteinuria, peripheral edema, hypoalbuminemia)? ☐ Yes ☐ No
(if Membranous Nephropathy) Does the patient have nephrotic proteinuria (greater than 3.5 gm/day after 6 months conservative therapy with ACEi or ARB)? ☐ Yes ☐ No
(if Membranous Nephropathy) Does the patient have recurrent membranous nephropathy? ☐ Yes ☐ No
(if Membranous Nephropathy, if yes) Does the patient have proteinuria greater than 1 gm/day? ☐ Yes ☐ No
(if Membranous Nephropathy, if yes) Has the patient received a kidney transplant? ☐ Yes ☐ No

(if MG) The covered alternatives are: immunosuppressive agents (for example, azathioprine, cyclosporine, or methotrexate). For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced.

(if MG) Per the information provided above, which of the following is true for your patient in regards to the covered alternatives?
- ☐ The patient tried 2 of the alternatives, but none of these drugs worked.
- ☐ The patient tried 2 of the alternatives, but they did not tolerate any of them.
- ☐ The patient cannot try 2 of these alternatives because of a contraindication to each of these drugs.
- ☐ other

(if PNS) Is the patient's disease relapsing? ☐ Yes ☐ No
(if PNS) Is the patient's disease steroid-dependent? ☐ Yes ☐ No

(if PNS) The covered alternative is corticosteroid or immunosuppressive medication (for example, cyclophosphamide, cyclosporine, mycophenolate mofetil). If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

(if PNS) Per the information provided above, which of the following is true for your patient in regards to the covered alternative?
- ☐ The patient tried one of the alternatives, but it didn't work.
- ☐ The patient tried one of the alternatives, but they did not tolerate it.
- ☐ The patient cannot try one of these alternatives because of a contraindication to this drug.
- ☐ other

(if Refractory Autoimmune Hemolytic Anemia) The covered alternative is conventional treatments (for example, corticosteroids, immunosuppressants, or immunoglobulin). If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

(if Refractory Autoimmune Hemolytic Anemia) Per the information provided above, which of the following is true for your patient in regard to the covered alternative?

- ☐ The patient tried one of the alternatives, but it didn't work.
- ☐ The patient tried one of the alternatives, but they did not tolerate it.
- ☐ The patient cannot try one of these alternatives because of a contraindication to this drug.
- ☐ other

(if Solid Organ Transplant) Is rituximab being used for either antibody mediated rejection (AMR) or for desensitization in highly allosensitized transplant candidate (to reduce HLA antibodies)? ☐ Yes ☐ No

(if TTP) Is rituximab being used in combination with plasma exchange therapy? ☐ Yes ☐ No

(if TTP) Will rituximab be used with glucocorticoids? ☐ Yes ☐ No

(if TTP - if no) Why won't the patient take rituximab with glucocorticoids?

- ☐ The patient tried one of the alternatives, but it didn't work.
- ☐ The patient tried one of the alternatives, but they did not tolerate it.
- ☐ The patient cannot try one of these alternatives because of a contraindication to this drug.
- ☐ other

(if TTP) Is this medication being prescribed by, or in consultation with, a hematologist? ☐ Yes ☐ No

(if Immunotherapy-Related Toxicities) Is this medication being prescribed by, or in consultation with, an oncologist, neurologist, rheumatologist, or dermatologist? ☐ Yes ☐ No

(if Immunotherapy-Related Toxicities) Will this medication be used for Initial Therapy or has the patient already received a course of a rituximab product for immunotherapy-related toxicities associated with checkpoint Inhibitors?

- ☐ Initial therapy
- ☐ Already received rituximab

(if Immunotherapy-Related Toxicities – initial) Has the patient tried at least one systemic corticosteroid (for example, methylprednisolone or prednisone) for this indication? ☐ Yes ☐ No

(if Immunotherapy-Related Toxicities – initial and YES) Is the patient symptomatic despite a trial of at least ONE systemic corticosteroid (for example, methylprednisolone or prednisone)? ☐ Yes ☐ No

(If RA, Pemphigus, MS) What is each dose in milligrams?

(If AAV, GVHD, ITP, NMO, immunotherapy related toxicities) What is the dose in milligrams or mg/m2? If unknown, please provide a current weight and height for your patient in addition to dose in milligrams.

What is the dosing schedule? Please be as specific as possible including course frequency, for example, 4 doses separated by at least 7 days per course, or two doses separated by at least 2 weeks.

(if RA) Is the requested dosing up to two 1,000 mg intravenous doses separated by at least 2 weeks with at least 16 weeks between courses? ☐ Yes ☐ No

(if AAV initial therapy) Is the requested dosing either A. 375 mg/m2 per dose administered intravenously for 4 doses separated by at least 7 days; or B. Up to two 1,000 mg intravenous doses separated by at least 2 weeks? ☐ Yes ☐ No

(AAV follow-up treatment adult) Is the requested dosing up to 1,000 mg administered by intravenous infusion every 4 to 6 months based on clinical evaluation, for up to 6 doses? ☐ Yes ☐ No

(AAV follow up pediatric) Is the requested dosing two - 250 mg/m2 intravenous infusions separated by two weeks, followed by a 250 mg/m2 intravenous infusion every 6 months thereafter based on clinical evaluation? ☐ Yes ☐ No

(Pemphigus vulgaris initial treatment or treatment of a relapse) Is the requested dosing for one course of therapy, which consists of up to two 1,000 mg doses administered as an intravenous infusion separated by at least 2 weeks? ☐ Yes ☐ No

(if Pemphigus vulgaris, maintenance therapy) Is the requested dosing up to 500 mg per dose administered intravenously at month 12 and every 6 months thereafter or based on clinical evaluation? ☐ Yes ☐ No

(if GVHD or ITP) Is the requested dosing 375 mg/m2 per dose administered intravenously with doses separated by at least 7 days? ☐ Yes ☐ No

(If MS) Is the requested dosing up to 2,000 mg (total) administered as one or two intravenous infusions administered over 1 month? ☐ Yes ☐ No

(If NMO) Is the requested dosing either A. 375 mg/m2 per dose administered intravenously for 4 doses separated by at least 7 days; or B. Up to two 1,000 mg doses separated by at least 2 weeks? ☐ Yes ☐ No

(If immunotherapy related toxicity) Is the requested dosing either i. Up to 500 mg/m2 administered intravenously for 2 doses separated by at least 14 days; or ii. Up to 375 mg/m2 administered intravenously for 4 doses separated by at least 7 days? ☐ Yes ☐ No

(For all diagnoses except RA) Supportive documentation for all answers must be attached with this request.

(Please note: there are different preferred products depending on your patient's plan. Please refer to the applicable Cigna health care professional resource [e.g. cignaforhcp.com] to determine benefit availability and the terms and conditions of coverage)

Additional Information:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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