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 for new start of therapy or continuation of therapy with the requested medication? If patient has been taking samples, please pick "new start".
☐ New start of therapy
☐ Continuation 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:

If Rituxan is being requested:

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.

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

(if allergic/adverse reaction to Riabni) 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

Please provide details to support.

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

(if allergic/adverse reaction to Ruxience) 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

Please provide details to support.

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

Please provide details to support.

If Acute lymphoblastic leukemia (ALL)):

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

Is this medication being used to initiate treatment? ☐ Yes ☐ No

If Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL):

Does the patient have relapsed or refractory disease? ☐ Yes ☐ No

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

Will this medication be used in combination with high-dose methylprednisolone (HDMP)? ☐ Yes ☐ No

Does your patient have significant comorbidities? ☐ Yes ☐ No

If Follicular lymphoma (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

Is this medication being given as single agent therapy? ☐ Yes ☐ No

Will this medication be used in combination with chemotherapy? ☐ Yes ☐ No

Splenic marginal zone lymphoma (SMZL)

Is this medication being used to initiate treatment? ☐ Yes ☐ No

****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.****

If any non-oncology diagnoses:

Will the medication requested be used in combination with any of the following medications: Enspryng, Soliris, Ultomiris, or Uplizna? ☐ Yes ☐ No
Is there documentation your patient has had a beneficial response with the requested medication? ☐ Yes ☐ No

Please provide support for continued use.

If Antineutrophil Cytoplasmic Antibody (ANCA)-associated vasculitis (AAV):

Is this medication being prescribed by, or in consultation with, a rheumatologist, nephrologist, or immunologist? ☐ Yes ☐ No

Will this medication be used for induction treatment or follow-up treatment after induction treatment [Note: This includes an individual who received induction treatment using a rituximab product or other standard of care immunosuppressants]? ☐ Yes ☐ No
☐ Induction treatment
☐ Follow-up treatment after induction treatment

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

Will this medication be used with glucocorticoids? ☐ Yes ☐ No

Why won't the patient take this medication 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

Factor Inhibitors in an Individual with Hemophilia

Was your patient refractory to conventional treatments [for example, immune tolerance induction (ITI), steroids, cyclophosphamide]? ☐ 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

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.

Per the information provided above, which of the following is true for your patient in regard 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 Immune or Idiopathic Thrombocytopenia (ITP):

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

Will this medication be used for Initial therapy or has the patient already received a course of a rituximab product for ITP?
☐ Initial therapy
☐ Already received rituximab

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.

Per the information provided above, which of the following is true for your patient in regard 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

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

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

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

If Immunotherapy-Related Toxicities Associated with Checkpoint Inhibitors:

Is this medication being prescribed by, or in consultation with, an oncologist, neurologist, rheumatologist, or dermatologist? ☐ Yes ☐ No

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

Has the patient tried at least one systemic corticosteroid (for example, methylprednisolone or prednisone) for this indication? ☐ Yes ☐ No

the patient symptomatic despite a trial of at least ONE systemic corticosteroid (for example, methylprednisolone or prednisone) ☐ Yes ☐ No

If Membranous Nephropathy/Membranous Glomerular Nephropathy:

Is this medication being prescribed by, or in consultation with, a nephrologist? ☐ Yes ☐ No

Does the patient have either eGFR less than 60 ml/min or declining renal function not otherwise explained? ☐ Yes ☐ No

Does the patient have nephrotic syndrome (nephrotic proteinuria, peripheral edema, hypoalbuminemia)? ☐ Yes ☐ No

Does the patient have nephrotic proteinuria (greater than 3.5 gm/day after 6 months of conservative therapy with ACEi or ARB)? ☐ Yes ☐ No

Does the patient have recurrent membranous nephropathy? ☐ Yes ☐ No

Does the patient have proteinuria greater than 1 gm/day? ☐ Yes ☐ No

Has the patient received a kidney transplant? ☐ Yes ☐ No

The covered alternatives are: at least TWO 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.

Per the information provided above, which of the following is true for your patient in regard 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

For each alternative that your patient didn't try, please provide details why they can't try that alternative including: contraindications according to the FDA label; warnings per the prescribing information (labeling); disease characteristic or clinical factor the patient has.

If Multiple Sclerosis (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.

Per the information provided above, which of the following is true for your patient in regard 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

Will this medication 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

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
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 Myasthenia Gravis (MG):

The covered alternatives are: at least TWO 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.

Per the information provided above, which of the following is true for your patient in regard 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

For each alternative that your patient didn't try, please provide details why they can't try that alternative including: contraindications according to the FDA label; warnings per the prescribing information (labeling); disease characteristic or clinical factor the patient has.
☐ Yes ☐ No
Is the patient's disease relapsing? ☐ Yes ☐ No

Is the patient's disease steroid-dependent? ☐ Yes ☐ No

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.

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 Neuromyelitis Optica Spectrum Disorder (NMO, Devic's disease):

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

Will the medication requested be used in combination with any of the following medications: Enspryng, Soliris, Ultomiris, or Uplizna? ☐ Yes ☐ No

Is there documentation your patient has had a beneficial response with the requested medication? ☐ Yes ☐ No

Please provide support for continued use.

If Pediatric Nephrotic Syndrome (PNS):

Is the patient's disease steroid-dependent? ☐ Yes ☐ No

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.

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 Pemphigus Vulgaris and Other Refractory Autoimmune Blistering Diseases (for example, pemphigus foliaceus, bullous pemphigoid, cicatricial pemphigoid, epidermolysis bullosa acquisita, and paraneoplastic pemphigus):

Is this medication being prescribed by, or in consultation with, a dermatologist? ☐ Yes ☐ No

Will this medication be used for initial treatment or for relapse/maintenance?
☐ Initial treatment
☐ Relapse/maintenance

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

Why won't the patient take this medication 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

Will subsequent infusions be administered no sooner than 16 weeks following the previous infusion of a rituximab product? ☐ Yes ☐ No

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.

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:

Which of the following best describes the place in therapy of the requested medication?
☐ Antibody-mediated rejection (AMR).
☐ Desensitization for highly-allosensitized transplant candidates (to reduce HLA antibodies).
☐ None of the above

If Systemic Lupus Erythematosus (SLE) (Lupus, Nephrotic Syndrome with SLE):

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

Will this medication be used for Initial Therapy or has the patient already received a course of a rituximab product for SLE?
☐ Initial treatment
☐ Already received rituximab

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.

Per the information provided above, which of the following is true for your patient in regard 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

Thrombotic Thrombocytopenic Purpura (TTP)

Is this medication being used in combination with plasma exchange therapy? ☐ Yes ☐ No

Will this medication be used with glucocorticoids? ☐ Yes ☐ No

Why won't the patient take this medication with glucocorticoids? ☐ Yes ☐ No
☐ 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

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

(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: *Please provide any additional clinical information that you feel is important to this review, including if the patient is currently taking the requested drug, including how they've been receiving it (samples, paying out of pocket, etc.) and how long they've been on it with dates.*

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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