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

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".*

What is your patient's current height? What is your patient's current weight?

What is each dose in milligrams (for example, 500mg)? ICD10:

What is the dosing schedule? Please be as specific as possible (for example, every 3 weeks for 12 weeks or weekly x 4 doses every 6 months):

What is the dose in mg/m2? (not needed for rheumatoid arthritis and leptomeningeal metastases):

How many treatments are currently anticipated?

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

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

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 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):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting*

Is this infusion occurring in a facility affiliated with hospital outpatient setting? ☐ Yes ☐ No

If yes- Is this patient a candidate for re-direction to an alternate setting (such as AIS, MDO, home) with assistance of a Specialty Care Option 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):

☐ **rheumatoid arthritis**

☐ **cancer diagnosis: **requires supportive documentation (i.e. chart notes, lab/test results, etc).**
Supportive documentation for all answers must be attached with this request.

- ☐ acute lymphoblastic leukemia (ALL)
- ☐ Castleman's disease (CD, giant lymph node hyperplasia, angiofollicular lymph node hyperplasia)
- ☐ chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)
- ☐ Hodgkin lymphoma (HL)
- ☐ leptomeningeal metastases
- ☐ B-cell non-Hodgkin lymphoma (NHL) (not CD20-positive)
- ☐ CD20-positive B-cell non-Hodgkin lymphoma (NHL)
  - ☐ AIDS-related B-cell lymphoma
  - ☐ B-cell lymphoblastic lymphoma
  - ☐ Burkitt lymphoma
  - ☐ diffuse large B-cell lymphoma (DLBCL)
  - ☐ follicular lymphoma (FL)
  - ☐ gastric MALT lymphoma
  - ☐ hairy cell leukemia
  - ☐ high grade B-cell lymphoma
  - ☐ histological transformation from nodal marginal zone lymphoma (NMZL) to diffuse large B-cell lymphoma (DLBCL)
  - ☐ low grade B-cell lymphoma
  - ☐ mantle cell lymphoma (MCL)
  - ☐ nodal marginal zone lymphoma (NMZL)
  - ☐ nongastric MALT lymphoma
  - ☐ post-transplant lymphoproliferative disorder (PTLD)
  - ☐ primary cutaneous B-cell lymphoma (CBCL)
  - ☐ splenic marginal zone lymphoma (SMZL)
  - ☐ other (please specify:)
- ☐ primary central nervous system lymphoma
- ☐ Waldenstrom's Macroglobulinemia (Lymphoplasmacytic lymphoma) (WM)
- ☐ other (please specify:)

☐ **non-cancer diagnosis: **requires supportive documentation (i.e. chart notes, lab/test results, etc).**
Supportive documentation for all answers must be attached with this request.

- ☐ ANCA-associated vasculitis/vasculitides (AAV)
- ☐ pemphigus vulgaris or other autoimmune blistering disease (for example, pemphigus foliaceus, bullous pemphigoid, cicatricial pemphigoid, epidermolysis bullosa acquisita, and paraneoplastic pemphigus)
- ☐ autoimmune hemolytic anemia (AIHA)
- ☐ chronic Graft Versus Host Disease (cGVHD)
- ☐ dermatomyositis (DM) or polymyositis (PM)
- ☐ hemophilia with factor inhibitors
- ☐ immune or idiopathic thrombocytopenia (ITP)
- ☐ myasthenia gravis (MG)
- ☐ neuromyelitis optica (NMO, Devic's disease)
- ☐ pediatric nephrotic syndrome (PNS)
- ☐ Sjögren's syndrome
- ☐ solid organ transplant
- ☐ systemic lupus erythematous (SLE)
- ☐ thrombotic thrombocytopenic purpura (TTP)
- ☐ other (please specify):

Clinical Information:

Rheumatoid Arthritis:

Is this for new start of therapy or continuation of therapy? ☐ new start ☐ continuation of therapy

(if continued therapy) Does your patient have a history of positive clinical response to with the requested drug therapy? ☐ Yes ☐ No

(if no) Please provide clinical support for continued use of the requested drug.

(if new start) Will the requested drug be taken in combination with methotrexate? ☐ Yes ☐ No

(if no) Does your patient have a contraindication per FDA label or documented intolerance to methotrexate? ☐ Yes ☐ No

(if no) What is the reason your patient will not be taking methotrexate?

(if new start with Rituxan) Does your patient have documentation of trials to ALL of the following: Riabni (rituximab-arrx), Ruxience (rituximab-pvvr), AND Truxima (rituximab-abbs)? ☐ Yes ☐ No

(if new start) Has your patient had FAILURE or inadequate response to any of the following biologic agents? (*check all that apply*):

☐ Cimzia ☐ Enbrel ☐ Humira ☐ Remicade ☐ Rinvoq ☐ Simponi (Aria) ☐ Other_____

(if new start) Does your patient have a contraindication per FDA label or documented intolerance, or is not a candidate for any of the following? (check all that apply):
☐ Cimzia ☐ Enbrel ☐ Humira ☐ Remicade ☐ Rinvoq ☐ Simponi (Aria) ☐ Other_____
(if new start) Has your patient had failure or inadequate response, contraindication per FDA label, or documented intolerance to at least one disease-modifying anti-rheumatic drug (DMARD) [for example, methotrexate, leflunomide, sulfasalazine]? ☐ 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)

Cancer Diagnosis:
Is this for new start of therapy or continuation of therapy? ☐ new start ☐ continuation of therapy
(if continued therapy) How many treatments has your patient already received?

(if new start with Rituxan) Does your patient have documentation of trials to ALL of the following: Riabni (rituximab-arrx), Ruxience (rituximab-pvvr), AND Truxima (rituximab-abbs)? ☐ Yes ☐ No

****This drug requires supportive documentation (i.e. chart notes, lab/test results, etc). Supportive documentation for all answers must be attached with this request.**

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

B-cell NHL:
(if requesting Riabni) Does your patient have CD20-positive disease? ☐ Yes ☐ No
(if requesting Riabni) Which of the following best describes your disease?
☐ diffuse large B-cell disease
☐ follicular disease
☐ low-grade disease
☐ none of the above

(if requesting Riabni and diffuse large B-cell disease) Has your patient previously been treated for this condition? ☐ Yes ☐ No
(if requesting Riabni and diffuse large B-cell disease) Is/Will the requested medication be(ing) used in combination with cyclophosphamide, doxorubicin, vincristine, and prednisone (CHOP) or some other anthracycline-based (Anthracyclines include daunorubicin [brand Vyxeos], doxorubicin [brands Adriamycin Doxil, Lipodox], epirubicin [brand Ellence], and idarubicin [brand Idamycin] chemotherapy regimen? ☐ Yes ☐ No
(if requesting Riabni and low-grade disease) Does your patient have relapsed or refractory disease? ☐ Yes ☐ No
(if requesting Riabni and follicular disease) Does your patient have relapsed or refractory disease? ☐ Yes ☐ No
(if relapsed/refractory) Is/Will the requested medication be(ing) used by itself to treat the disease? ☐ Yes ☐ No
(if low-grade and not relapsed/refractory) Does your patient have non-progressing (stable) disease? ☐ Yes ☐ No
(if non-progressing) Is/Will the requested medication be(ing) used by itself to treat the disease? ☐ Yes ☐ No
(if non-progressing) Is the requested medication being given after first-line cyclophosphamide, vincristine, and prednisone (CVP) chemotherapy? ☐ Yes ☐ No
(if follicular and not relapsed/refractory) Which of these best describes previous treatment for this disease?
☐ this patient has not been treated for this disease before this drug
☐ treated with a rituximab product (Riabni, Rituxan, Ruxience, Truxima) and other chemotherapy
☐ neither of the above
(if previously untreated) Is/Will the requested medication be(ing) used in combination with first line chemotherapy? ☐ Yes ☐ No
(if rituximab and chemo before) Did your patient achieve a complete or partial response to the rituximab (Riabni, Rituxan, Ruxience, Truxima) product with other chemotherapy? ☐ Yes ☐ No
(if rituximab and chemo before) Is/Will the requested medication be(ing) used by itself to treat the disease? ☐ Yes ☐ No
(if rituximab and chemo before) Is/Will the requested medication be(ing) used as maintenance therapy? ☐ Yes ☐ No

(if requesting Ruxience or Truxima) Is the requested drug being used after first-line treatment with CVP (cyclophosphamide [Cytoxan], vincristine [Oncovin, Vincasar PFS], and prednisone) regimen? ☐ Yes ☐ No
(if after first-line CVP and requesting Ruxience or Truxima) Does your patient have stable (not progressing) disease? ☐ Yes ☐ No
(if after first-line CVP and requesting Ruxience or Truxima) Is the requested drug the ONLY one that will be used for the treatment of the diagnosis at this time? ☐ Yes ☐ No
(if NOT after first-line CVP, CD20 positive and requesting Ruxience or Truxima) 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/unknown
(if previously untreated, CD20 positive and requesting Ruxience or Truxima) Will the requested drug be used in combination with other chemotherapy? ☐ Yes ☐ No
(relapsed or refractory, CD20 positive and requesting Ruxience or Truxima) Is the requested drug the ONLY one that will be used for the treatment of the diagnosis at this time? ☐ Yes ☐ No
(if maintenance therapy, CD20 positive and requesting Ruxience or Truxima) Did your patient have a partial or complete response to first-line treatment with rituximab product (Riabni, Rituxan, Ruxience, Truxima) in combo with other chemotherapy? ☐ Yes ☐ No

(if maintenance therapy, CD20 positive and requesting Ruxience or Truxima) Is the requested drug the ONLY one that will be used for the treatment of the diagnosis at this time? ☐ Yes ☐ No

BCL:

(if requesting Rituxan)Is the requested drug being given in combination with gemcitabine (Gemzar) and vinorelbine (Navelbine)? ☐ Yes ☐ No

CLL/SLL:

(if under 65 years of age and requesting Rituxan) Does your patient have significant comorbidities? ☐ Yes ☐ No

(if no comorbidities and requesting Rituxan) Has your patient failed purine analogs (such as fludarabine, pentostatin [Nipent], or cladribine)? ☐ Yes ☐ No

(if no failure to purine analogs and requesting Rituxan) Is the requested drug being given as single agent first-line therapy? ☐ Yes ☐ No

(if requesting Riabni or Ruxience) Is/Will the requested drug be(ing) used in combination with fludarabine and cyclophosphamide? ☐ Yes ☐ No

(if requesting Riabni or Ruxience) Does your patient have CD20-positive disease? ☐ Yes ☐ No

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

(if requesting Truxima) Does your patient have relapsed or refractory disease? ☐ Yes ☐ No

CBCL, DLBCL, FL, non-gastric MALT lymphoma:

(if requesting Rituxan)Is the requested drug being given as part of R-CHOP-14 treatment (dose dense R-CHOP given every 14 days)? ☐ Yes ☐ No

CBCL, gastric and non-gastric MALT lymphoma, SMZL:

(if requesting Rituxan) Is the requested drug being given in combination with lenalidomide (Revlimid)? ☐ Yes ☐ No

DLBCL:

(if requesting Rituxan) Is the requested drug being used in combination with vinorelbine (Navelbine)? ☐ Yes ☐ No

FL:

(if requesting Ruxience or Truxima) 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/unknown

(if previously untreated and requesting Ruxience or Truxima) Will the requested drug be used in combination with other chemotherapy? ☐ Yes ☐ No

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

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

(if maintenance therapy and requesting Ruxience or Truxima) Is the requested drug the ONLY one that will be used for the treatment of the diagnosis at this time? ☐ Yes ☐ No

Non-gastric MALT lymphoma, SMZL:

(if requesting Rituxan) Has your patient previously received any chemotherapy for this diagnosis? ☐ Yes ☐ No

Low-grade B-cell lymphoma:

(if requesting Ruxience or Truxima) Which best describes your patient?

☐ relapsed or refractory disease
☐ received first-line treatment with CVP (cyclophosphamide [Cytoxan], vincristine [Oncovin, Vincasar PFS], and prednisone) regimen
☐ neither of the above/unknown

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

(if treated with CVP and requesting Ruxience or Truxima) Does your patient have stable (not progressing) disease? ☐ Yes ☐ No

(if treated with CVP and requesting Ruxience or Truxima) Is the requested drug the ONLY one that will be used for the treatment of the diagnosis at this time? ☐ Yes ☐ No

MALT lymphoma, NMZL, SMZL:

(if requesting Ruxience or Truxima) Is the requested drug being used to initiate treatment in this patient? ☐ Yes ☐ No

MCL:

(fi requestiong Rituxan) Is the requested drug being used in combination with PEPC (prednisone [Deltasone], etoposide, procarbazine [Matulane], and cyclophosphamide) regimen? ☐ Yes ☐ No

Non-Cancer Diagnosis:

Is this for new start of therapy or continuation of therapy? ☐ new start ☐ continuation of therapy

(if new start with Rituxan) Does your patient have documentation of trials to ALL of the following: Riabni (rituximab-arrx), Ruxience (rituximab-pvvr), AND Truxima (rituximab-abbs)? ☐ Yes ☐ No

****This drug requires supportive documentation (i.e. chart notes, lab/test results, etc). Supportive documentation for all answers must be attached with this request.**

AAV:
Which of the following associated conditions does your patient have?
- ☐ granulomatosis with polyangiitis (GPA)/Wegener's granulomatosis (WG)
- ☐ Churg-Strauss syndrome
- ☐ microscopic polyangiitis (MPA)
- ☐ pauci-immune glomerulonephritis
- ☐ none of the above

autoimmune blistering disease, AIHA, hemophilia:
Was your patient refractory to conventional treatments? ☐ Yes ☐ No

cGHVD:
Does your patient have refractory cGvHD? ☐ Yes ☐ No

DM or PM:
Has your patient's diagnosis been established by a biopsy? ☐ Yes ☐ No
Has your patient had failure of standard medical therapy (corticosteroids AND immunosuppressants)? ☐ Yes ☐ No

ITP:
Does your patient have failure/inadequate response, contraindication per FDA label, or intolerance to at least one prior agent for this diagnosis? ☐ Yes ☐ No

MG:
Does your patient have failure/inadequate response, contraindication per FDA label, intolerance or not a candidate to TWO immunosuppressive agents (for example: azathioprine, cyclosporine, or methotrexate)? ☐ Yes ☐ No

NMO:
Please provide chart notes to support a diagnosis of NMO.

PNS:
Which applies to your patient?
- ☐ patient has relapsing disease
- ☐ patient has steroid-dependent disease
- ☐ both of the above
- ☐ none of the above

Does your patient have failure or inadequate response, contraindication per FDA label, or documented intolerance to any of the following: corticosteroids (for example, dexamethasone, methylprednisolone, prednisone), cyclophosphamide, cyclosporine, mycophenolate mofetil? ☐ Yes ☐ No

Sjögren's syndrome:
Does your patient have systemic manifestations of the disease (for example: cryoglobulinemia associated with vasculitis, vasculitis, severe parotid swelling, inflammatory arthritis, pulmonary disease)? ☐ Yes ☐ No
Does your patient have failure/inadequate response, contraindication per FDA label, intolerance or not a candidate to ONE immunosuppressive agent? ☐ Yes ☐ No

solid organ transplant:
Is the requested drug being used for either antibody mediated rejection (AMR) or for desensitization in highly allosensitized transplant candidate (to reduce HLA antibodies)? ☐ Yes ☐ No

SLE:
Does your patient have a documented failure/inadequate response, intolerance, contraindication per FDA label, or not a candidate to ONE immunosuppressive agent (for example: azathioprine, cyclophosphamide, mycophenolic mofetil)? ☐ Yes ☐ No
Does your patient have neuropsychiatric manifestations of SLE (for example: refractory acute confusional state or other psychiatric disorders [such as lupus psychosis], severe peripheral nervous system disorders [such as, polyneuropathy, mononeuropathy, plexopathy]) OR lupus nephritis? ☐ Yes ☐ No

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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