Rituxan (rituximab)

**Line(s) of Business:**
- HMO; PPO; QUEST Integration
- Akamai Advantage

**Original Effective Date:**
10/01/2015

**Current Effective Date:**
05/01/2017

**POLICY**

**A. INDICATIONS**

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

**FDA-Approved Indications**

- **Non-Hodgkin’s Lymphoma (NHL)**
  - Rituxan is indicated for the treatment of patients with:
    - Relapsed or refractory, low-grade or follicular, CD20-positive, B-cell NHL as a single agent
    - Previously untreated follicular, CD20-positive, B-cell NHL in combination with first line chemotherapy and, in patients achieving a complete or partial response to Rituxan in combination with chemotherapy, as single-agent maintenance therapy
    - Non-progressing (including stable disease), low-grade, CD20-positive, B-cell NHL, as a single agent after first-line CVP (cyclophosphamide, vincristine, and prednisone) chemotherapy
    - Previously untreated diffuse large B-cell, CD20-positive NHL in combination with cyclophosphamide, doxorubicin, vincristine, and prednisone (CHOP) or other anthracycline-based chemotherapy regimens
- **Chronic Lymphocytic Leukemia (CLL)**
  - Rituxan is indicated, in combination with fludarabine and cyclophosphamide (FC), for the treatment of patients with previously untreated and previously treated CD20-positive CLL.
- **Rheumatoid Arthritis**
  - Rituxan in combination with methotrexate (MTX) is indicated for the treatment of adult patients with moderately to severely active rheumatoid arthritis who have an inadequate response to one or more tumor necrosis factor (TNF) antagonist therapies.
- **Wegener’s Granulomatosis* (WG) and Microscopic Polyangiitis (MPA)**
  - Rituxan, in combination with glucocorticoids, is indicated for the treatment of adult patients with WG and MPA.
*Also known as granulomatosis with polyangiitis (GPA)

**Compendial Uses**

- Acute lymphoblastic leukemia in combination with chemotherapy
- Central nervous system (CNS) cancers
  - Primary CNS lymphoma
  - Leptomeningeal metastases from lymphomas
• Hodgkin’s lymphoma, nodular lymphocyte-predominant
• Non-Hodgkin’s lymphoma
  o Acquired immunodeficiency syndrome (AIDS)-related B-cell lymphoma
  o Burkitt lymphoma, in combination with chemotherapy
  o Castleman’s disease
  o Diffuse large B-cell lymphoma, in combination with chemotherapy or as a single agent in non-transplant candidates
  o Hairy cell leukemia, relapsed or refractory
  o Lymphoblastic lymphoma
  o Mantle cell lymphoma
  o Marginal zone lymphomas (gastric/non-gastric MALT, splenic marginal zone lymphoma)
  o Post-transplant lymphoproliferative disorder (PTLD)
  o Primary cutaneous B-cell lymphoma
  o Small lymphocytic lymphoma (SLL)
• Waldenström’s macroglobulinemia/lymphoplasmacytic lymphoma
• Myasthenia gravis, refractory

B. REQUIRED DOCUMENTATION
• For all approvable oncologic or hematologic indications:
  o Testing or analysis confirming CD20 protein on the surface of the B-cell (if applicable)
  o Initial therapy: current oncology or hematology notes, clinical notes (including previous treatment history), and any pertinent pathology reports and/or imaging studies
  o Continuation therapy: documentation demonstrating lack of disease progression on therapy

C. PRESCRIBER RESTRICTION
• For all oncologic or hematologic indications, Rituxan must be prescribed recommended by an oncologist or a hematologist.

D. CRITERIA FOR INITIAL APPROVAL
1. Oncologic or Hematologic Indications
   For oncologic or hematologic disorders, the tumor must be CD20-positive as confirmed by testing or analysis to identify the CD20 protein on the surface of the B-cell.

1.1 Acute lymphoblastic leukemia (ALL)
   Initial authorization of 6 months may be granted for members who are prescribed Rituxan as a component of a chemotherapy regimen.

1.2 Central nervous system (CNS) cancers
   Initial authorization of 6 months may be granted for members who are prescribed Rituxan for any of the following indications:
   a. Primary CNS lymphoma
   b. Leptomeningeal metastases from lymphoma

1.3 Hodgkin’s lymphoma
   Initial authorization of 6 months may be granted for members who are prescribed Rituxan for the treatment of nodular lymphocyte-predominant Hodgkin’s lymphoma.
1.4 Non-Hodgkin’s lymphoma (NHL)

a. Initial authorization of 6 months may be granted for members who are prescribed Rituxan for any of the following indications:
   i. Diffuse large B-cell lymphoma
   ii. AIDS-related B-cell lymphoma
   iii. Chronic Lymphocytic Leukemia (CLL) / Small lymphocytic lymphoma (SLL)
   iv. Follicular lymphoma
   v. Hairy cell leukemia, relapsed or refractory
   vi. Lymphoblastic lymphoma
   vii. Mantle cell lymphoma
   viii. Marginal zone lymphoma (splenic or MALT)
   ix. Post-transplant lymphoproliferative disorder (PTLD)
   x. Primary cutaneous B-cell lymphoma
   xi. Castleman’s disease

b. Initial authorization of 6 months may be granted for members who are prescribed Rituxan as a component of a chemotherapy regimen for the treatment of Burkitt lymphoma.

c. Initial authorization of 6 months may be granted for members who are prescribed Rituxan for the treatment of diffuse large B-cell lymphoma and meet either of the following criteria:
   i. Rituxan is prescribed as a component of a chemotherapy regimen
   ii. Member has relapsed or refractory disease and either of the following:
       o Member is not a candidate for high-dose therapy with autologous stem cell rescue.
       o Member is a candidate for high-dose therapy with autologous stem cell rescue and Rituxan is prescribed as a component of a chemotherapy regimen.

1.5 Waldenström’s macroglobulinemia/lymphoplasmacytic lymphoma (LPL)

Initial authorization of 6 months may be granted for members who are prescribed Rituxan for the treatment of Waldenström’s macroglobulinemia/lymphoplasmacytic lymphoma (LPL).

2. Moderately to severely active rheumatoid arthritis (RA)

a. Initial authorization of 6 months may be granted to members who meet both of the following criteria:
   i. Member has either of the following:
      a) Inadequate response to at least a 3-month trial of a TNF inhibitor (e.g., Cimzia, Enbrel, Humira, Remicade, Simponi, Simponi Aria)
      b) Intolerance or contraindication to a TNF inhibitor
   ii. Member is prescribed Rituxan in combination with MTX or has a contraindication or intolerance to MTX.

3. Granulomatosis with Polyangiitis (GPA; Wegener’s Granulomatosis) and Microscopic Polyangiitis (MPA)

Initial authorization of 6 months may be granted to members who are prescribed Rituxan for the treatment of GPA or MPA.

4. Myasthenia Gravis

Initial authorization of 6 months may be granted to members who are prescribed Rituxan for the treatment of myasthenia gravis that is refractory to corticosteroids and/or immunomodulating drugs (eg, azathioprine, IVIG).
E. RE-AUTHORIZATION/CONTINUATION OF THERAPY
Members who have had Rituxan previously authorized by HMSA/CVS are subject to the continuation criteria below for approval. Members without previous authorization are required to meet criteria for initial authorization in section D. above.

1. Oncologic or Hematologic indications
   Authorization of 6 months may be granted for continuation of therapy when there is no evidence of disease progression.

2. Rheumatoid arthritis, granulomatosis with polyangiitis (Wegener’s granulomatosis) and microscopic polyangiitis and myasthenia gravis
   Authorization of 12 months may be granted for members who achieve or maintain positive clinical response to therapy as evidenced by low disease activity or improvement in signs and symptoms of the condition.

F. DOSAGE AND ADMINISTRATION
   Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

G. ADMINISTRATIVE GUIDELINES
   Precertification is required. Please refer to the HMSA medical policy web site for the fax form.

G.H. IMPORTANT REMINDER
   The purpose of this Medical Policy is to provide a guide to coverage. This Medical Policy is not intended to dictate to providers how to practice medicine. Nothing in this Medical Policy is intended to discourage or prohibit providing other medical advice or treatment deemed appropriate by the treating physician.

   Benefit determinations are subject to applicable member contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

   This Medical Policy has been developed through consideration of the medical necessity criteria under Hawaii’s Patients’ Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4), generally accepted standards of medical practice and review of medical literature and government approval status. HMSA has determined that services not covered under this Medical Policy will not be medically necessary under Hawaii law in most cases. If a treating physician disagrees with HMSA’s determination as to medical necessity in a given case, the physician may request that CVS/caremark reconsider the application of the medical necessity criteria to the case at issue in light of any supporting documentation.

H. REFERENCES

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<td>10/01/2015</td>
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<tr>
<td>03/2016</td>
<td>Revised prescriber restriction (added hematologist)</td>
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<td>11/2016</td>
<td>Editorial revision (added ‘hematology’ to oncology/hematology sections)</td>
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<td>12/13/2016</td>
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