Rituxan, Riabni, Ruxience, Truxima

HMSACOM - 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 1-866-237-5512**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414.** 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:** _____
Patient's Phone Number: _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

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

Additional Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*ft* _____*inches*

Indicate where the drug is being dispensed:

❑ Office ❑ Outpatient Hospital ❑ Ambulatory Surgical ❑ Inpatient Hospital
❑ Off Campus Outpatient Hospital ❑ Urgent Care ❑ Emergency Room ❑ Birthing Center
❑ Military Facility ❑ Skilled Nursing Facility ❑ Nursing Facility ❑ Hospice
❑ Inpatient Psychiatric ❑ Psychiatric Residential Treatment ❑ End Stage Renal Facility
❑ Psychiatric Facility ❑ Pharmacy ❑ Other

Indicate where the drug is being administered:

❑ Ambulatory surgical ❑ Home ❑ Inpatient Hospital
❑ Office ❑ Outpatient Hospital ❑ Pharmacy

What is the ICD-10 code? _____

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512

 Rituxan, Riabni, Ruxience, Truxima MR HMSACOM C26293-A, C11158-A – 04/2026.

Exception Criteria Questions:

A. What product is being requested?

❑ Riabni, *Continue to Question E*

❑ Rituxan, *Continue to Question B*

❑ Ruxience, *Skip to Question B*

❑ Truxima, *Skip to Question E*

B. The preferred products for your patient's health plan are Riabni and Truxima
Can the patient's treatment be switched to a preferred product?

❒ Yes, Riabni, *Continue to Question E*

❒ Yes, Truxima, *Continue to Question E*

❒ No, *Continue to Question C*

C. Does the patient have a documented intolerable adverse event to treatment with both of the preferred products, Riabni and Truxima? ***Action Required***: *If 'Yes', attach supporting chart note(s)*

❒ Yes, *Continue to Question D*

❒ No, *Skip to Question E*

D. Was the documented intolerable adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the reference product and biosimilar products)? ***Action Required***: *If 'No', attach supporting chart note(s)*

❒ Yes, *Continue to Question E*

❒ No, *Continue to Question E*

E. Is the requested drug being used for an oncology diagnosis?

❒ Yes, *Skip to #900*

❒ No, *Continue to Criteria Questions*

Criteria Questions:

1. What is the diagnosis?
❒ Rheumatoid arthritis (RA), *Continue to #2*
❒ Wegener's granulomatosis (granulomatosis with polyangiitis) or microscopic polyangiitis, *Continue to #100*
❒ Non-Hodgkin's lymphoma (NHL), *Continue to #900*
❒ Chronic lymphocytic leukemia (CLL), *Continue to #900*
❒ Small lymphocytic lymphoma (SLL), *Continue to #900*
❒ Pemphigus vulgaris, *Continue to #750*
❒ Leptomeningeal metastases from lymphomas, *Continue to #900*
❒ Primary central nervous system (CNS) lymphoma, *Continue to #900*
❒ Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma (LPL), *Continue to #900*
❒ Acute lymphoblastic leukemia (ALL), *Continue to #900*
❒ Hodgkin's lymphoma, *Continue to #900*
❒ Myasthenia gravis, *Continue to #700*
❒ Immunotherapy-related toxicities, *Continue to #800*
❒ Autoimmune hemolytic anemia, *Continue to #800*
❒ Immune or idiopathic thrombocytopenic purpura, *Continue to #800*
❒ Thrombotic thrombocytopenic purpura, *Continue to #800*
❒ Membranous nephropathy, *Continue to #150*
❒ Other, *No Further Questions*

RHEUMATOID ARTHRITIS

2. Is the requested drug being prescribed by or in consultation with an immunologist, rheumatologist or nephrologist?
❒ Yes, *Continue to #3*
❒ No, *Continue to #3*

3. Is the member an adult?
❒ Yes, *Continue to #4*
❒ No, *Continue to #4*

4. Was rituximab previously authorized by HMSA/CVS for this member?
❒ Yes, *Continue to #15*
❒ No, *Continue to #5*
❒ Unknown, *Continue to #5*

INITIAL AUTHORIZATION

5. Will the requested drug be used in combination with methotrexate or leflunomide?
❒ Yes, *Continue to #7*
❒ No, *Continue to #6*

6. Does the patient have a contraindication or history of intolerance to methotrexate or leflunomide?
❒ Yes, *Continue to #7*
❒ No, *Continue to #7*

7. Has the patient ever received (including current utilizers) a biologic or targeted synthetic drug (e.g., Rinvoq, Xeljanz) indicated for moderately to severely active rheumatoid arthritis?
❒ Yes, *No Further Questions*
❒ No, *Continue to #8*

8. Has the patient been tested for either of the following biomarkers and the test was positive: a) rheumatoid factor (RF) biomarker OR b) anti-cyclic citrullinated peptide (anti-CCP) biomarker?
❒ Yes, *Continue to #10*
❒ No, *Continue to #9*

9. Has the patient been tested for ALL of the following biomarkers: A) rheumatoid factor (RF), B) anti-cyclic citrullinated peptide (anti-CCP) biomarker AND c) C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR)?
❒ Yes, *Continue to #10*
❒ No, *Continue to #10*

10. Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate at a dose greater than or equal to 15 mg per week?
❒ Yes, *No Further Questions*
❒ No, *Continue to #11*

11. Has the patient experienced an intolerance to methotrexate?
❒ Yes, *Continue to #14*
❒ No, *Continue to #12*

12. Does the patient have a contraindication to methotrexate?
❒ Yes, *Continue to #13*
❒ No, *Continue to #13*

13. Please indicate the contraindication
❒ History of intolerance or adverse event, *Continue to #14*
❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease, *Continue to #14*
❒ Elevated liver transaminases, *Continue to #14*
❒ Interstitial pneumonitis or clinically significant pulmonary fibrosis, *Continue to #14*
❒ Renal impairment, *Continue to #14*
❒ Pregnancy or currently planning pregnancy, *Continue to #14*
❒ Breastfeeding, *Continue to #14*
❒ Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia), *Continue to #14*
❒ Myelodysplasia, *Continue to #14*
❒ Hypersensitivity, *Continue to #14*
❒ Significant drug interaction, *Continue to #14*
❒ Other, *Continue to #14*

14. Has the patient experienced an inadequate response to another conventional drug (e.g., hydroxychloroquine, leflunomide, sulfasalazine)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

RE-AUTHORIZATION

15. Since starting rituximab, has the member benefitted from treatment as evidenced by one of the following?
❒ Yes – Low disease activity, *No Further Questions*
❒ Yes – Improvement in signs and symptoms, *No Further Questions*
❒ Yes – Maintenance of improvement in signs and symptoms, *No Further Questions*
❒ No, *No Further Questions*

WEGENER'S GRANULOMATOSIS (granulomatosis with polyangiitis) or MICROSCOPIC POLYANGIITIS

100. Is the requested drug prescribed by or in consultation with an immunologist, rheumatologist or nephrologist?
❒ Yes, *Continue to #101*
❒ No, *Continue to #101*

101. Was rituximab previously authorized by HMSA/CVS for this member?
❒ Yes, *Continue to #102*
❒ No, *No Further Questions*
❒ Unknown, *No Further Questions*

RE-AUTHORIZATION

102. Has the member benefitted from rituximab treatment as evidenced by one of the following?
❒ Yes – Low disease activity as measured by a standardized disease activity measurement tool/scale (eg, Birmingham Vasculitis Activity Score)
❒ Yes – Improvement in signs and symptoms, *No Further Questions*
❒ Yes – Maintenance of improvement in signs and symptoms, *No Further Questions*
❒ No, *No Further Questions*

MEMBRANOUS NEPHROPATHY

150. Is the requested drug being prescribed by or in consultation with a nephrologist?
❒ Yes, *Continue to #151*
❒ No, *Continue to #151*

151. Was rituximab therapy previously authorized by HMSA/CVS for this member?
❒ Yes, *Continue to #152*
❒ No, *Continue to #153*
❒ Unknown, *Continue to #153*

RE-AUTHORIZATION

152. Since starting rituximab, has the member benefitted from treatment as evidenced by one of the following:
❒ Yes – Low disease activity, *No Further Questions*
❒ Yes – Improvement in signs and symptoms, *No Further Questions*
❒ Yes – Maintenance of improvement in signs and symptoms, *No Further Questions*
❒ No, *No Further Questions*

INITIAL AUTHORIZATION

153. Is the member at high risk for disease progression?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

MYASTHENIA GRAVIS

700. Is the requested drug being prescribed by or in consultation with an immunologist, neurologist, or rheumatologist?
❒ Yes, *Continue to #701*
❒ No, *Continue to #701*

701. Was rituximab therapy previously authorized by HMSA/CVS for this member?
❒ Yes, *Continue to #702*
❒ No, *No Further Questions*
❒ Unknown, *No Further Questions*

RE-AUTHORIZATION

702. Since starting rituximab, has the member benefitted from treatment as evidenced by one of the following?
❒ Yes – Low disease activity, *No Further Questions*
❒ Yes – Improvement in signs and symptoms, *No Further Questions*
❒ Yes – Maintenance of improvement in signs and symptoms, *No Further Questions*
❒ No, *No Further Questions*

PEMPHIGUS VULGARIS

750. Is the requested drug prescribed by or in consultation with an immunologist or dermatologist?
❒ Yes, *Continue to #751*
❒ No, *Continue to #751*

751. Was rituximab therapy previously authorized by HMSA/CVS for this member?
❒ Yes, *Continue to #753*
❒ No, *Continue to #752*
❒ Unknown, *Continue to #752*

INITIAL AUTHORIZATION

752. Does the member have disease that is moderate to severe?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

RE-AUTHORIZATION

753. Since starting rituximab, has the member benefitted from treatment as evidenced by one of the following?
❒ Yes – Low disease activity, *No Further Questions*
❒ Yes – Improvement in signs and symptoms, *No Further Questions*
❒ Yes – Maintenance of improvement in signs and symptoms, *No Further Questions*
❒ No, *No Further Questions*

AUTOIMMUNE HEMOLYTIC ANEMIA, IMMUNE/IDIOPATHIC/THROMBOTIC THROMBOCYTOPENIC PURPURA, IMMUNOTHERAPY-RELATED TOXICITIES

800. Is the requested drug being prescribed by or in consultation with a hematologist or oncologist?
❒ Yes, *Continue to #801*
❒ No, *Continue to #801*

801. Was rituximab therapy previously authorized by HMSA/CVS for this member?
❒ Yes, *Continue to #890*
❒ No, *Continue to #802*
❒ Unknown, *Continue to #802*

INITIAL AUTHORIZATION

802. What is the diagnosis?
❒ Autoimmune hemolytic anemia, *Continue to #810*
❒ Immune or idiopathic thrombocytopenic purpura, *Continue to #820*
❒ Thrombotic thrombocytopenic purpura, *Continue to #830*
❒ Immunotherapy-related toxicities, *Continue to #803*

803. Does the member have immunotherapy-related encephalitis?
❒ Yes, *Continue to #804*
❒ No, *Continue to #804*

804. Have viral causes been excluded?
❒ Yes, *Continue to #805*
❒ No, *Continue to #805*

805. Has the member tested positive for autoimmune encephalopathy antibody?
❒ Yes, *Continue to #806*
❒ No, *Continue to #806*

806. Has the member tried methylprednisolone with or without IVIG and had limited or no improvement?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

810. Does the member have autoimmune hemolytic anemia that is refractory to steroids?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

820. Does the member have immune or idiopathic thrombocytopenic purpura that is refractory to steroids or intravenous immunoglobulin (IVIG)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

830. Does the member have thrombotic thrombocytopenic purpura that is refractory to plasma exchange or steroids?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

RE-AUTHORIZATION

890. Since starting rituximab, has the member benefitted from treatment as evidenced by one of the following:
❒ Yes – Low disease activity as measured by a standardized disease activity measurement tool/scale (e.g., Birmingham Vasculitis Activity Score) , *No Further Questions*
❒ Yes – Improvement in signs and symptoms, *No Further Questions*
❒ Yes – Maintenance of improvement in signs and symptoms, *No Further Questions*
❒ No, *No Further Questions*

ONCOLOGIC INDICATIONS

900. Please list or describe all agents in the oncology regimen. ❑ Single agent ❑ Multiple agents

_____

_____

901. What is the patient's diagnosis and ICD 10 code? ***ACTION REQUIRED: Please attach relevant and supportive data of patient's diagnosis.***

_____

902. Is the requested medication/regimen prescribed for an FDA-approved indication, an indication supported by NCCN with a I or IIA recommendation? ❑ Yes ❑ No

903. Does the patient have a contraindication to the use of the requested medication(s) as listed in the medication(s) prescribing information? ❑ Yes ❑ No

904. Was the single agent or entire drug regimen previously authorized by HMSA/CVS for this member?
❑ Yes ❑ No ❑ Unknown *If No or unknown, no further questions.*

905. Is there evidence to support the patient is benefitting from treatment (e.g. positive clinical response, lack of disease progression)? ***ACTION REQUIRED: Please attach current clinical documentation (e.g., office visit notes and applicable studies) that supports treatment is beneficial.*** ❑ 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)**