



Rituxan, Riabni, Ruxience, Truxima

HMSA Medicare Advantage - 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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Rituxan, Riabni, Ruxience, Truxima HMSAMED MR C26294-A, C26513-A – 01/2026.

CVS Caremark Specialty Programs • 2969 Mapunapuna Place • Honolulu, HI 96819
Phone: 1-808-254-4414 • Fax: 1-866-237-5512 • www.caremark.com

Exception Criteria Questions:

A. What product is being requested?

- Riabni, *Continue to Question F*
- Rituxan, *Continue to Question B*
- Ruxience, *Continue to Question B*
- Truxima, *Continue to Question F*

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 F*
- Yes, Truxima, *Continue to Question F*
- No, *Continue to Question C*

C. Has the patient received treatment with the requested product in the past 365 days?

- Yes, *Continue to Question F*
- No, *Continue to Question D*

D. 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 E*
- No, *Continue to Question E*

E. 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 F*
- No, *Continue to Question F*

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

- Yes, *If Yes, skip to #202*
- No, *Continue to Criteria Questions*

Criteria Questions:

1. Is the patient currently receiving treatment with the requested drug?

- Yes, *Continue to #200*
- No, *Continue to #2*

2. What is the diagnosis?

- Rheumatoid arthritis (RA), *Continue to #25*
- Immune or idiopathic thrombocytopenia (ITP), *No Further Questions*
- Autoimmune hemolytic anemia, *No Further Questions*
- Thrombotic thrombocytopenic purpura (TTP), *No Further Questions*
- Wegener's granulomatosis (also known as granulomatosis with polyangiitis) or microscopic polyangiitis, *No Further Questions*

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Rituxan, Riabni, Ruxience, Truxima HMSAMED MR C26294-A, C26513-A – 01/2026.

**CVS Caremark Specialty Programs • 2969 Mapunapuna Place • Honolulu, HI 96819
Phone: 1-808-254-4414 • Fax: 1-866-237-5512 • www.caremark.com**

- Myasthenia gravis, *Continue to #80*
- Pemphigus vulgaris, *No Further Questions*
- Oncology indication, *Continue to #202*
- Other, *No Further Questions*

Rheumatoid arthritis

25. Has the patient been previously treated with a biologic or targeted synthetic disease-modifying drug (DMARD) (e.g., TNF inhibitor, Xeljanz) for rheumatoid arthritis?

- Yes, *No Further Questions*
- No, *Continue to #26*

26. Has the patient had an inadequate response to methotrexate or leflunomide?

- Yes, *No Further Questions*
- No, *Continue to #27*

27. Is there a clinical reason to avoid treatment with methotrexate or leflunomide (e.g., renal or hepatic impairment)?

- Yes, *No Further Questions*
- No, *No Further Questions*

Myasthenia gravis (e.g., minimal change disease)

80. Is the patient's condition refractory to standard therapy (e.g., corticosteroids, immunosuppressants)?

- Yes, *No Further Questions*
- No, *Continue to #81*

81. Is there a clinical reason to avoid treatment with standard therapy?

- Yes, *No Further Questions*
- No, *No Further Questions*

Continuation of Therapy

200. What is the diagnosis?

- Rheumatoid arthritis (RA), *Continue to #201*
- Immune or idiopathic thrombocytopenia (ITP), *Continue to #201*
- Autoimmune hemolytic anemia, *Continue to #201*
- Thrombotic thrombocytopenic purpura (TTP), *Continue to #201*
- Wegener's granulomatosis (also known as granulomatosis with polyangiitis) or microscopic polyangiitis, *Continue to #201*
- Myasthenia gravis, *Continue to #201*
- Pemphigus vulgaris, *Continue to #201*
- Oncology indication, *Continue to #202*
- Other, *No Further Questions*

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Rituxan, Riabni.,Ruxience, Truxima HMSAMED MR C26294-A, C26513-A – 01/2026.

**CVS Caremark Specialty Programs • 2969 Mapunapuna Place • Honolulu, HI 96819
Phone: 1-808-254-4414 • Fax: 1-866-237-5512 • www.caremark.com**

201. Is the member receiving benefit from therapy with the requested drug?

Yes, *No Further Questions*

No, *No Further Questions*

Oncologic Indications

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

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

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

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

206. 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.*

207. 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)

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Rituxan, Riabni., Ruxience, Truxima HMSAMED MR C26294-A, C26513-A – 01/2026.

**CVS Caremark Specialty Programs • 2969 Mapunapuna Place • Honolulu, HI 96819
Phone: 1-808-254-4414 • Fax: 1-866-237-5512 • www.caremark.com**