Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

# Riabni, 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 ☐ 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 Non-Hodgkin's lymphoma (NHL)
- ☐ Burkitt lymphoma
- ☐ Castleman's disease
- ☐ Central nervous system cancers (for example, leptomeningeal metastases [intra-cerebrospinal fluid (CSF) treatment]; primary central nervous system lymphoma)
- ☐ Chronic lymphocytic leukemia/Small lymphocytic lymphoma (CLL/SLL)
- ☐ Diffuse large B-cell lymphoma
- ☐ Follicular lymphoma (FL)
- ☐ Gastric MALT lymphoma
- ☐ Hairy cell leukemia
- ☐ High-grade B-cell lymphoma
- ☐ Histologic transformation of nodal marginal zone lymphoma to diffuse large B-cell lymphoma
- ☐ Hodgkin lymphoma (HL) [for example, lymphocyte-predominant Hodgkin lymphoma (LPHL)]
- ☐ Low grade B cell lymphoma
- ☐ Mantle cell lymphoma
- ☐ Nodal marginal zone lymphoma
- ☐ Non-gastric MALT lymphoma
- ☐ Post-transplant lymphoproliferative disorder (PTLD)
- ☐ Splenic marginal zone lymphoma
- ☐ Waldenstrom's macroglobulinemia/Lymphoplasmacytic lymphoma
- ☐ other cancer diagnosis not listed above

**Non-oncology diagnoses:**

- ☐ Autoimmune hemolytic anemia
- ☐ Antineutrophil cytoplasmic antibody (ANCA)-associated vasculitis
- ☐ Graft-versus-host disease
- ☐ Hematopoietic cell transplantation
- ☐ Immune thrombocytopenia (ITP)
- ☐ Immunotherapy-related toxicities associated with checkpoint inhibitors [examples of checkpoint inhibitors are Keytruda (pembrolizumab intravenous infusion), Opdivo (nivolumab intravenous infusion), Yervoy (ipilimumab intravenous infusion), Tecentriq (atezolizumab intravenous infusion), Bavencio (avelumab intravenous infusion), Imfinzi (durvalumab intravenous infusion), and Libtayo (cemiplimab-rwlc intravenous infusion)]
- ☐ Interstitial lung disease associated with systemic autoimmune rheumatic disease - Please Note: Examples of systemic autoimmune rheumatic diseases include systemic sclerosis, myositis, mixed connective tissue disease, rheumatoid arthritis, and Sjogren's disease.
- ☐ Membranous nephropathy
- ☐ Minimal change disease
- ☐ Multiple sclerosis (MS)
- ☐ Myasthenia gravis (MG)
- ☐ Neuromyelitis optica spectrum disorder
- ☐ Pediatric nephrotic syndrome
- ☐ Pemphigus vulgaris
- ☐ Rheumatoid arthritis
- ☐ Solid organ transplantation
- ☐ Systemic lupus erythematous (SLE) [Lupus] (includes nephrotic syndrome in a patient with SLE)
- ☐ Thrombotic thrombocytopenic purpura (TTP)
- ☐ other non-cancer diagnosis not listed above

**Clinical Information:**

**If Acute lymphoblastic leukemia (ALL):**

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

**If B-cell Non-Hodgkin's lymphoma (NHL):**

Does the patient have non-progressing (including stable disease) disease? ☐ Yes ☐ No

Does the patient have CD20 positive B-cell Non-Hodgkin's lymphoma (NHL)? ☐ Yes ☐ No

Which of the following best applies to your patient?
☐ Achieving a complete or partial response to a rituximab product in combination with chemotherapy
☐ Previously untreated disease
☐ Relapsed or refractory disease
☐ None of the above

Is the requested medication being used as maintenance therapy? ☐ Yes ☐ No

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

Is this medication being given in combination with lenalidomide and tafasitamab-cxix ? ☐ Yes ☐ No

Will this medication be used in combination with chemotherapy? ☐ 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

**If Follicular lymphoma (FL):**

Which of the following best applies to your patient?
☐ Achieving a complete or partial response to a rituximab product in combination with chemotherapy
☐ Previously untreated disease
☐ Relapsed or refractory disease
☐ None of the above

Is the requested medication being used as maintenance therapy? ☐ Yes ☐ No

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

(if previously untreated) Will this medication be used in combination with chemotherapy? ☐ Yes ☐ No

(if relapsed/refractory, not single agent therapy) Will this medication be used in combination with lenalidomide and tafasitamab-cxix? ☐ Yes ☐ No

**If Low grade B-cell lymphoma:**

Which of the following best applies to your patient?
☐ Non-progressing (including stable disease) disease
☐ Relapsed or refractory disease
☐ None of the above

Is the requested medication being used after first line cyclophosphamide, vincristine, and prednisone (CVP) chemotherapy? ☐ Yes ☐ No

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

Is this medication being given in combination with lenalidomide and tafasitamab-cxix ? ☐ Yes ☐ No

**If Gastric MALT lymphoma, Nodal marginal zone lymphoma, Non-gastric MALT lymphoma, or Splenic marginal zone lymphoma**

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

****For non-oncology diagnoses****

**If Autoimmune hemolytic anemia:**

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

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

Is the request for induction treatment OR follow-up treatment of patients who have received induction treatment?
☐ Induction treatment
☐ Follow-up treatment of patients who have received induction treatment

(for ANCA-associated vasculitis – Induction) Is this medication being prescribed by, or in consultation with, a rheumatologist, nephrologist, pulmonologist, or immunologist? ☐ Yes ☐ No

(for ANCA-associated vasculitis – Induction) Does the patient have an ANCA-associated vasculotide? [Note: Examples of ANCA-associated vasculitis include granulomatosis with polyangiitis (GPA) (Wegener's granulomatosis), or microscopic polyangiitis (MPA)]. ☐ Yes ☐ No

(for ANCA-associated vasculitis – Induction) Is the requested medication being administered in combination with glucocorticoids? ☐ Yes ☐ No

(for ANCA-associated vasculitis - Follow-Up Treatment) According to the prescriber, has the patient achieved disease control with induction treatment? ☐ Yes ☐ No

(for ANCA-associated vasculitis - Follow-Up Treatment) Will at least 16 weeks elapse between courses? ☐ Yes ☐ No

**If Graft-Versus-Host Disease:**

Has the patient already received a course of a rituximab product for graft-versus host disease? ☐ Yes ☐ No

(If GvHD, new start) Does the patient have chronic graft-versus-host disease? ☐ Yes ☐ No

(If GvHD, new start) Is this medication being prescribed by, or in consultation with, an oncologist, hematologist, or a physician affiliated with a transplant center? ☐ Yes ☐ No

(If GvHD, new start) Has the patient tried at least one systemic medication for graft-versus-host disease? Note: Examples include systemic corticosteroids (methylprednisolone, prednisone), Jakafi (ruxolitinib), Rezurock (belumosudil), Niktimvo (axatilimab-csfr), cyclosporine, tacrolimus, mycophenolate mofetil, Imbruvica (ibrutinib), imatinib, hydroxychloroquine, methotrexate, Nipent (pentostatin), interleukin-2 (for example, Proleukin [aldesleukin]), sirolimus, or an etanercept product. ☐ Yes ☐ No

(If GvHD, has received) When assessed by at least one objective measure, has the patient experienced a beneficial clinical response from baseline (prior to initiating a rituximab product)? Note: Examples of objective measures is normalization of liver function tests, red blood cell count, or platelet count, or resolution of fever or rash. ☐ Yes ☐ No

(if GvHD, has received) Compared with baseline (prior to initiating a rituximab product), has the patient experienced an improvement in at least one symptom, such as improvement in skin, oral mucosal, ocular, or gastrointestinal symptoms (for example, nausea, vomiting, anorexia)? ☐ Yes ☐ No

**If Hematopoietic Cell Transplantation**

Will the requested medication be used as part of a conditioning regimen for allogeneic transplant? ☐ Yes ☐ No

Is the requested medication being prescribed by or in consultation with an oncologist, hematologist, or a physician affiliated with a transplant center? ☐ Yes ☐ No

**If Immune or Idiopathic Thrombocytopenia (ITP):**

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

(If ITP, initial therapy) Is this medication being prescribed by, or in consultation with, a hematologist? ☐ Yes ☐ No

(If ITP, initial therapy) Has the patient tried one other therapy? Please Note: Examples of therapies for ITP include intravenous immunoglobulin (IVIG), anti-D (RHO) immunoglobulin, corticosteroids, Alvaiz (eltrombopag), Doptelet (avatrombopag), Nplate (romiplostim), Promacta (eltrombopag), Tavalisse (fostamatinib), and splenectomy. ☐ Yes ☐ No

(if ITP, has received) Will at least 6 months elapse between treatment courses? Note: 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

(if ITP, has received) According to the prescriber, has the patient responded to therapy? Note: For example, platelet count increased from baseline following treatment with a rituximab product. ☐ Yes ☐ No

(if ITP, has received) According to the prescriber has the patient relapsed? Note: For example, the patient experiences thrombocytopenia after achievement of a remission. ☐ Yes ☐ No

**If Immunotherapy-Related Toxicities Associated with Checkpoint Inhibitors:**

Is the requested medication being prescribed by, or in consultation with, an oncologist, hematologist, nephrologist, 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?
☐ Initial treatment
☐ The patient has already received a course of a rituximab product

(if initial treatment) According to the prescriber, has the patient developed an immunotherapy-related toxicity? ☐ Yes ☐ No

(If initial treatment) Has the patient developed this immunotherapy-related toxicity while receiving a checkpoint inhibitor? ☐ Yes ☐ No

(If initial treatment) Is the patient symptomatic despite a trial of at least ONE systemic corticosteroid? Please Note: Examples of a corticosteroid include methylprednisolone and prednisone. ☐ Yes ☐ No

**If Interstitial Lung Disease associated with Systemic Autoimmune Rheumatic Disease:**

Is the requested medication being prescribed by or in consultation with a pulmonologist or a rheumatologist? ☐ Yes ☐ No

Is the request for initial treatment OR has the patient already received a course of a rituximab product for interstitial lung disease associated with systemic autoimmune rheumatic disease?
☐ Initial treatment
☐ The patient has already received a course of a rituximab product for interstitial lung disease associated with systemic autoimmune rheumatic disease.

(if Interstitial lung disease, initial) Is the diagnosis confirmed by high-resolution computed tomography? ☐ Yes ☐ No

(if Interstitial lung disease, received course of rituximab) Will at least 24 weeks elapse between treatment courses? Please Note: For example, there will be a minimum of 24 weeks since the first dose of the previous course and the first dose of the next course of a rituximab product. ☐ Yes ☐ No

(if Interstitial lung disease, received course of rituximab) Has the patient experienced a beneficial response to therapy with rituximab? Please Note: Examples of a beneficial response include a reduction in the anticipated decline in forced vital capacity, improvement in 6-minute walk distance, and/or reduction in the number or severity of disease-related exacerbations. ☐ Yes ☐ No

**If Membranous Nephropathy/Membranous Glomerular Nephropathy:**

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

Has the patient already received a course of a rituximab product for membranous nephropathy? ☐ Yes ☐ No

(if Membranous nephropathy, not received course of rituximab) According to the prescriber, is the patient at moderate risk or high risk for the progressive loss of kidney function? ☐ Yes ☐ No

Is the requested medication being prescribed by or in consultation with a nephrologist? ☐ Yes ☐ No

**If Multiple Sclerosis (MS):**

Will the requested medication be used in combination with another disease-modifying agent used for multiple sclerosis? Note: Examples of disease-modifying agents for MS include Aubagio (teriflunomide tablets, generics), Avonex (interferon beta-1a intramuscular injection), Bafiertam (monomethyl fumarate delayed-release capsules), Betaseron (interferon beta-1b subcutaneous injection), Briumvi (ublituximab-xiiy intravenous infusion), Copaxone (glatiramer acetate subcutaneous injection, generic), Gilenya (fingolimod capsules, generic), Glatopa (glatiramer acetate subcutaneous injection), Kesimpta (ofatumumab subcutaneous injection), Lemtrada (alemtuzumab intravenous infusion), Mavenclad (cladribine tablets), Mayzent (siponimod tablets), Ocrevus (ocrelizumab intravenous infusion), Ocrevus Zunovo (ocrelizumab and hyaluronidase-ocsq subcutaneous injection), Plegridy (peginterferon beta-1a subcutaneous or intramuscular injection), Ponvory (ponesimod tablets), Rebif (interferon beta-1a subcutaneous injection), Tascenso ODT (fingolimod orally disintegrating tablets), Tecfidera (dimethyl fumarate delayed-release capsules, generic), Tyruko (natalizumab-sztn intravenous infusion), Tysabri (natalizumab intravenous infusion), Vumerity (diroximel fumarate delayed-release capsules), and Zeposia (ozanimod capsules). ☐ Yes ☐ No

Is the requested medication being prescribed by or in consultation with a neurologist or a physician who specializes in the treatment of multiple sclerosis? ☐ Yes ☐ No

Will at least 6 months elapse between treatment courses? Note: For example, if the patient has already received a course of therapy 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 therapy. ☐ Yes ☐ No

Is the patient currently receiving rituximab? ☐ Yes ☐ No

(if Multiple Sclerosis, not currently receiving rituximab) According to the prescriber, has the patient experienced inadequate efficacy or significant intolerance to at least TWO other disease-modifying agent for multiple sclerosis? Note: Examples of disease-modifying agents for MS include Aubagio (teriflunomide tablets, generics), Avonex (interferon beta-1a intramuscular injection), Bafiertam (monomethyl fumarate delayed-release capsules), Betaseron (interferon beta-1b subcutaneous injection), Briumvi (ublituximab-xiiy intravenous infusion), Copaxone (glatiramer acetate subcutaneous injection, generic), Gilenya (fingolimod capsules, generic), Glatopa (glatiramer acetate subcutaneous injection), Kesimpta (ofatumumab subcutaneous injection), Lemtrada (alemtuzumab intravenous infusion), Mavenclad (cladribine tablets), Mayzent (siponimod tablets), Ocrevus (ocrelizumab intravenous infusion), Ocrevus Zunovo (ocrelizumab and hyaluronidase-ocsq subcutaneous injection), Plegridy (peginterferon beta-1a subcutaneous or intramuscular injection), Ponvory (ponesimod tablets), Rebif (interferon beta-1a subcutaneous injection), Tascenso ODT (fingolimod orally disintegrating tablets), Tecfidera (dimethyl fumarate delayed-release capsules, generic), Tyruko (natalizumab-sztn intravenous infusion), Tysabri (natalizumab intravenous infusion), Vumerity (diroximel fumarate delayed-release capsules), and Zeposia (ozanimod capsules). ☐ Yes ☐ No

(if Multiple Sclerosis, currently receiving rituximab) Has the patient been receiving rituximab for 1 year or more? ☐ Yes ☐ No

(if Multiple Sclerosis, currently receiving rituximab) Has the patient experienced a beneficial clinical response when assessed by at least one objective measure? Note: Examples include stabilization or reduced worsening in disease activity as evaluated by magnetic resonance imaging (MRI) [absence or a decrease in gadolinium enhancing lesions, decrease in the number of new or enlarging T2 lesions]; stabilization or reduced worsening on the Expanded Disability Status Scale (EDSS) score; achievement in criteria for No Evidence of Disease Activity-3 (NEDA-3) or NEDA-4; improvement on the fatigue symptom and impact questionnaire-relapsing multiple sclerosis (FSIQ-RMS) scale; reduction or absence of relapses; improvement or maintenance on the six-minute walk test or 12-Items Multiple Sclerosis Walking Scale; improvement on the Multiple Sclerosis Functional Composite (MSFC) score; and or attenuation of brain volume loss. ☐ Yes ☐ No

(if Multiple Sclerosis, currently receiving rituximab) Has the patient experienced stabilization, slow progression, or improvement in at least one symptoms such as motor function, fatigue, vision, bowel/bladder function, spasticity, walking/gait, or pain/numbness/tingling sensation? ☐ Yes ☐ No

**If Myasthenia Gravis (MG):**

Is the requested medication being prescribed by or in consultation with a neurologist? ☐ Yes ☐ No

Has the patient already received a course of a rituximab product for myasthenia gravis? ☐ Yes ☐ No

(if Myasthenia gravis, already received course of rituximab) According to the prescriber, is the patient continuing to derive benefit from the rituximab product? - Please Note: Examples of benefit include reductions in exacerbations of myasthenia gravis; improvements in speech, swallowing, mobility, and respiratory function. ☐ Yes ☐ No

if Myasthenia gravis, not already received course of rituximab) Does the patient have confirmed anti-muscle-specific tyrosine kinase antibody-positive myasthenia gravis? ☐ Yes ☐ No

(if Myasthenia gravis, not already received course of rituximab) Has the patient previously received, or is the patient currently receiving, pyridostigmine? ☐ Yes ☐ No

(if Myasthenia gravis, not already received course of rituximab, no pyridostigmine) Has the patient had inadequate efficacy, a contraindication, or significant intolerance to pyridostigmine? ☐ Yes ☐ No

(if Myasthenia gravis, not already received course of rituximab, no pyridostigmine) Has the patient tried at least one immunosuppressant therapy? Please Note: Examples of immunosuppressant therapies include azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus, and cyclophosphamide. A trial of Imaavy (nipocalimab-aahu intravenous infusion) or Rystiggo (rozanolixizumab-noli subcutaneous infusion) also counts. ☐ Yes ☐ No

(if Myasthenia gravis, not already received course of rituximab, no pyridostigmine) Does the patient have evidence of unresolved symptoms of myasthenia gravis? Please Note: Evidence of unresolved symptoms of myasthenia gravis includes difficulty swallowing, difficulty breathing, or a functional disability resulting in the discontinuation of physical activity (for example, double vision, talking, impairment of mobility). ☐ Yes ☐ No

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

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

**If Pediatric Nephrotic Syndrome (PNS):**

Is the requested medication being prescribed by or in consultation with a nephrologist? ☐ Yes ☐ No

Has the patient already received a course of a rituximab product for pediatric nephrotic syndrome? ☐ Yes ☐ No

Has the patient tried at least one systemic corticosteroid? Please Note: Examples of systemic corticosteroids include prednisone or prednisolone. ☐ Yes ☐ No

Has the patient tried at least one glucocorticoid-sparing agent for nephrotic syndrome? Please Note: Examples of glucocorticoid-sparing agents for nephrotic syndrome include oral calcineurin inhibitors (for example, tacrolimus, cyclosporine), cyclophosphamide, or mycophenolate mofetil. ☐ Yes ☐ No

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

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

Is the request for initial treatment OR is the patient being treated for a relapse or for maintenance of pemphigus vulgaris?
☐ Initial treatment
☐ Treatment of relapse
☐ Maintenance

(if Initial treatment) Is the requested medication being initiated in combination with a corticosteroid unless contraindicated? Please Note: An example of a corticosteroid is prednisone. ☐ Yes ☐ No

(if Relapse/Maintenance) Will subsequent infusions be administered no sooner than 16 weeks following the previous infusion of a rituximab product? Note: For example, there will be a minimum of 16 weeks since the first dose of the previous course and the first dose of the next course of a rituximab product. ☐ Yes ☐ No

**If Refractory Autoimmune Hemolytic Anemia:**

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

**If Rheumatoid Arthritis:**

Will the requested medication be used in combination with a BIOLOGIC or targeted synthetic disease-modifying antirheumatic drug?
☐ Biologic (such as Cimzia, adalimumab products, etanercept products, infliximab products, Simponi [Aria or SC], tocilizumab products, Kevzara, Kineret, and Orencia [IV or SC])
☐ Targeted synthetic DMARD (such as Olumiant, Otezla, Otezla XR, Xeljanz/XR, or Rinvoq)
☐ Conventional synthetic DMARD (such as methotrexate, leflunomide, sulfasalazine, hydroxychloroquine))
☐ No, the requested medication will NOT be used in combination with another BIOLOGIC or targeted synthetic (DMARD)

Has the patient already received one or more courses of a rituximab product for rheumatoid arthritis? ☐ Yes ☐ No

(if RA - one or more courses of rituximab product) Has it been 16 weeks or greater since the first dose of the previous rituximab product? Note: For example, there will be a minimum of 16 weeks since the first dose of the previous course and the first dose of the next course of a rituximab product. ☐ Yes ☐ No

(if RA - one or more courses of rituximab product) Has the patient already received two or more courses of a rituximab product for rheumatoid arthritis? ☐ Yes ☐ No

(if RA - two or more courses of rituximab product) Has the patient experienced a beneficial clinical response when assessed by at least one objective measure? Note: Examples of standardized and validated measures of disease activity include Clinical Disease Activity Index (CDAI), Disease Activity Score (DAS) 28 using erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP), Patient Activity Scale (PAS)-II, Rapid Assessment of Patient Index Data 3 (RAPID-3), and/or Simplified Disease Activity Index (SDAI). ☐ Yes ☐ No

(if RA - two or more courses of rituximab product) Has the patient experienced an improvement in at least one symptom, such as decreased joint pain, morning stiffness, or fatigue; improved function or activities of daily living; decreased soft tissue swelling in joints or tendon sheaths? ☐ Yes ☐ No

(if RA - not already receive one or more courses of rituximab product) Is this medication being prescribed by or in consultation with a rheumatologist? ☐ Yes ☐ No

(if RA - not already receive one or more courses of rituximab product) Has the patient tried one conventional synthetic disease-modifying antirheumatic drug (DMARD) for at least 3 months? Note: Examples of conventional synthetic DMARDs are methotrexate [oral or injectable], leflunomide, sulfasalazine, and hydroxychloroquine. ☐ Yes ☐ No

(if RA - not already receive one or more courses of rituximab product) Has the patient tried one biologic disease-modifying antirheumatic drug (DMARD), other than the requested drug, for at least 3 months? Note: Biosimilars of the requested drug do not count. Examples of biologic DMARDs are Cimzia, an adalimumab product (Humira, biosimilar), an infliximab product (Remicade, biosimilar), Kevzara, Simponi Aria or SC, a tocilizumab product (IV or SC) [Actemra, biosimilar], Kineret, and Orencia (IV or SC). ☐ Yes ☐ No

**If Solid Organ Transplant:**

Will the medication be used for desensitization therapy prior to or immediately after transplantation? ☐ Yes ☐ No

Will the medication be used for antibody-mediated rejection? ☐ Yes ☐ No

Is the requested medication being prescribed by or in consultation with a physician affiliated with a transplant center? ☐ Yes ☐ No

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

Is the request for initial therapy OR has the patient already received a course of rituximab product for SLE?
☐ Initial Therapy
☐ The patient has already received a course of rituximab for SLE

(if initial therapy) Is the requested medication being prescribed by or in consultation with a rheumatologist, nephrologist, or neurologist? ☐ Yes ☐ No

(if initial therapy) Has the patient tried at least ONE standard immunomodulating or immunosuppressant agent? Please Note: Examples of standard immunomodulating or immunosuppressant agents include hydroxychloroquine, corticosteroids (for example, prednisone, methylprednisolone), methotrexate, azathioprine, mycophenolate, and cyclophosphamide. ☐ Yes ☐ No

(has received) Will 6 months or greater elapse between treatment courses? Please Note: for example, if the patient has already received a course of rituximab there will be a minimum of 6 months separating the first dose of the previous rituximab course and the first dose of the requested course of rituximab. ☐ Yes ☐ No

**If Thrombotic Thrombocytopenic Purpura (TTP)**

Will the medication be used in combination with systemic corticosteroids? Please Note: Examples of systemic corticosteroids include prednisone and methylprednisolone. ☐ Yes ☐ No

Will the medication be used in combination with therapeutic plasma exchange? ☐ Yes ☐ No

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:**

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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