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

Rituxan
(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:
☐ Rituxan

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

What is the indication or diagnosis?

☐ Acute lymphoblastic leukemia (ALL)
☐ Antineutrophil Cytoplasmic Antibody (ANCA)-Associated Vasculitis
☐ Autoimmune hemolytic anemia
☐ Central nervous system cancers (that is, leptomeningeal metastases [intracerebrospinal fluid (CSF) treatment]; primary central nervous system lymphoma)
☐ Chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL)
☐ Follicular lymphoma (FL)
☐ Graft versus host disease (GVHD)
☐ Hematopoietic cell transplantation
☐ Hodgkin lymphoma (HL) (including lymphocyte-predominant Hodgkin lymphoma/LPHL)
☐ Immune thrombocytopenia (ITP)
☐ Immunotherapy-related toxicities associated with checkpoint inhibitors - Please Note: 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
☐ Myasthenia gravis
☐ Neuromyelitis optica (NMO) spectrum disorder
☐ Non-Hodgkin lymphoma (NHL) - including AIDS-related B-cell lymphoma, diffuse large B-cell, high grade B-cell lymphoma, Burkitt lymphoma, Castleman's Disease, gastric MALT lymphoma, hairy cell leukemia, histologic transformation of indolent lymphoma to diffuse large B-cell lymphoma, B-cell lymphoblastic lymphoma, mantle cell lymphoma, nodal marginal zone lymphoma, non-gastric MALT lymphoma, post-transplant lymphoproliferative disorder (PTLD), primary cutaneous B-cell lymphoma (NOT including follicular lymphoma, chronic lymphocytic leukemia/small lymphocytic lymphoma [CLL/SLL], or splenic marginal zone lymphoma)
☐ Pediatric nephrotic syndrome
☐ Pemphigus Vulgaris
☐ Rheumatoid arthritis (RA)
☐ Solid organ transplantation
☐ Splenic marginal zone lymphoma
☐ Systemic lupus erythematous (SLE) [Lupus]. This includes nephrotic syndrome in a patient with SLE.
☐ Thrombotic thrombocytopenic purpura
☐ Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma
☐ All other indications and diagnoses

Clinical Information:

(if non-oncology diagnosis) Is documentation being provided that the patient has tried ALL of the following formulary alternatives: Truxima, Riabni, and Ruxience? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

(if yes) Is documentation being provided that the patient cannot continue to use due to a formulation difference in the inactive ingredient(s) [for example, differences in stabilizing agent, buffering agent, and/or surfactant] between the requested medication and ALL the alternative products which, according to the prescriber, would result in a significant allergy or serious adverse reaction? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

(if oncology diagnosis) Has the patient tried ALL of the following alternative products: i. Riabni (rituximab-arrx) [may require prior authorization]; ii. Ruxience (rituximab-pvvr) [may require prior authorization]; iii. Truxima (rituximab-abbs) [may require prior authorization]? ☐ Yes ☐ No

(if yes) Has the patient cannot continue to use due to a formulation difference in the inactive ingredient(s) between the requested medication and ALL the alternative products which, according to the prescriber, would result in a significant allergy or serious adverse reaction? ☐ Yes ☐ No

****ONCOLOGY Diagnoses****

If Acute lymphoblastic leukemia (ALL):

Does the patient have Philadelphia chromosome-negative (PH-) ALL? ☐ 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

Will this medication be used in combination with high-dose methylprednisolone (HDMP)? ☐ Yes ☐ No

(if less than 65 years old) Does your patient have significant comorbidities? ☐ Yes ☐ No

If Follicular lymphoma (FL):

Which of the following best describes the place in therapy of the requested medication?
☐ As maintenance therapy after achieving a complete or partial response to a rituximab product (Riabni, Rituxan, Rituxan Hycela, Ruxience, Truxima) in combination with chemotherapy
☐ In previously untreated disease
☐ For relapsed or refractory disease
☐ None of the above

(if FL, maintenance) Is this medication being given as single agent therapy? ☐ Yes ☐ No

(if FL, previously treated disease) Will this medication be used in combination with chemotherapy? ☐ Yes ☐ No

(if FL, relapsed or refractory disease) Is this medication being given as single agent therapy? ☐ Yes ☐ No

(if no) Will this medication be used in combination with lenalidomide and tafasitamab-cxix? ☐ Yes ☐ No

Splenic marginal zone lymphoma (SMZL):

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

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

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. Please Note: This includes patients who received induction treatment using a rituximab product or other standard of care immunosuppressants.

(if induction) Is the requested medication being prescribed by or in consultation with a rheumatologist, nephrologist, pulmonologist, or immunologist? ☐ Yes ☐ No

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

(if induction) Is the requested medication being administered in combination with glucocorticoids? ☐ Yes ☐ No

(if follow-up) Has the patient achieved disease control with induction treatment, according to the prescriber? ☐ Yes ☐ No

(if follow-up) Will at least 16 weeks elapse between courses? ☐ Yes ☐ No

If Autoimmune Hemolytic Anemia:

Is the requested medication being prescribed by or in consultation with a hematologist? ☐ 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 not already received a course of rituximab) Does the patient have chronic graft-versus-host disease? ☐ Yes ☐ No

(if not already received a course of rituximab) 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 not already received a course of rituximab) Has the patient tried at least one systemic medication for graft versus host disease? - Please 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 already received a course of rituximab) When assessed by at least one objective measure, has the patient experienced a beneficial clinical response from baseline (prior to initiating a rituximab product)? Please Note: An example 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 no) 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 Thrombocytopenia (ITP):

Is the request for initial treatment OR has the patient already received a course of rituximab for ITP?
☐ Initial treatment
☐ The patient has already received a course of rituximab for ITP.

(if initial) Is the requested medication being prescribed by or in consultation with a hematologist? ☐ Yes ☐ No

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

(if already received a course of rituximab) According to the prescriber, has the patient relapsed? Please 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

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

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

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

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

(if already received a 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 already received a 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:

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

(if not already received a 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 Minimal Change Disease:

Has the patient already received a course of a rituximab product for minimal change disease? ☐ Yes ☐ No

(if not already received a course of rituximab) Is the medication being used for frequently relapsing or steroid-dependent disease? ☐ 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? Please 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? Please 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 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? - Please 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 currently receiving rituximab) Has the patient been receiving rituximab for 1 year or more? ☐ Yes ☐ No

(if receiving for 1yr or more) Has the patient experienced a beneficial clinical response when assessed by at least one objective measure? Please 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 no) Has the patient experienced stabilization, slow progression, or improvement in at least one symptom such as motor function, 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 already received a 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 not already received a course of rituximab) Does the patient have confirmed anti-muscle-specific tyrosine kinase antibody-positive myasthenia gravis? ☐ Yes ☐ No

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

(if no) Has the patient had inadequate efficacy, a contraindication, or significant intolerance to pyridostigmine? ☐ Yes ☐ No

(if not already received a course of rituximab) 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 not already received a course of rituximab) 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 (NMO) Spectrum Disorder:

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

If Pediatric Nephrotic Syndrome:

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

(if not already received a course of rituximab) Has the patient tried at least one systemic corticosteroid? Please Note: Examples of systemic corticosteroids include prednisone or prednisolone. ☐ Yes ☐ No

(if 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:

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 is the patient being treated for maintenance of pemphigus vulgaris?

☐ Initial treatment
☐ Patient is being treated for a relapse of pemphigus vulgaris
☐ Patient is being treated for maintenance of pemphigus vulgaris

(if initial) 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) 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 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 Rheumatoid Arthritis:

Will the requested medication be used in combination with a BIOLOGIC or targeted synthetic disease-modifying antirheumatic drug (DMARD)?
☐ 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 disease-modifying antirheumatic drug (DMARD) (such as Olumiant, Otezla, Otezla XR, Xeljanz/XR, or Rinvoq)
☐ Conventional synthetic disease-modifying antirheumatic drug (DMARD) (such as methotrexate, leflunomide, sulfasalazine, hydroxychloroquine)
☐ No, the requested medication will NOT be used in combination with another BIOLOGIC or targeted synthetic disease-modifying antirheumatic drug (DMARD)

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

(if yes) Has it been 16 weeks or greater since the first dose of the previous rituximab product? Please 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 received one or more courses of rituximab) Has the patient already received two or more courses of a rituximab product for rheumatoid arthritis? ☐ Yes ☐ No

(if yes) Has the patient experienced a beneficial clinical response when assessed by at least one objective measure? Please 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 no) 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 no previous courses of rituximab) Is this medication being prescribed by or in consultation with a rheumatologist? ☐ Yes ☐ No

(if no previous courses of rituximab) Has the patient tried one conventional synthetic disease-modifying antirheumatic drug (DMARD) (brand or generic; oral or injectable) for at least 3 months? Please Note: Examples of conventional synthetic DMARDs are methotrexate [oral or injectable], leflunomide, sulfasalazine, and hydroxychloroquine. ☐ Yes ☐ No

(if no) Has the patient tried one biologic, other than the requested drug, for at least 3 months? Please Note: Biosimilars of the requested drug do not count. Examples of biologics 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).
Notes: Please note: A biosimilar of the requested biologic does NOT count. ☐ Yes ☐ No

If Solid Organ Transplantation:

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

(if 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

Is the prescribed dose based on a transplant center's protocol? ☐ 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 IV for SLE?
☐ Initial therapy
☐ The patient has already received a course of rituximab for SLE

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

(if initial) 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

(if already received a course of rituximab) 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 the requested 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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