Prescriber Criteria Form Truxima 2024 PA Fax 4710-A v3 010124.docx Truxima (rituximab-abbs) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Truxima (rituximab-abbs).

Drug Name: Truxima (rituximab-abbs)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of one of the following types of cluster of differentiation 20 (CD20)-positive, B-cell non-Hodgkin's lymphoma (NHL): A) follicular lymphoma, B) marginal zone lymphomas (nodal, splenic, extranodal marginal zone lymphoma), C) mantle cell lymphoma, D) Burkitt lymphoma, E) human immunodeficiency virus (HIV)-related B-cell lymphoma, F) chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), G) post-transplant lymphoproliferative disorder (PTLD), H) primary cutaneous B-cell lymphoma, I) diffuse large B-cell lymphoma, J) Castleman's disease, K) hairy cell leukemia, L) high-grade B-cell lymphoma, M) relapsed, refractory, or non-progressing low-grade, N) histological transformation from indolent lymphomas to diffuse large B-cell lymphoma, O) histological transformation from CLL/SLL to diffuse large B-cell lymphoma, P) B-cell lymphoblastic lymphoma, Q) pediatric aggressive mature B-cell lymphomas (including Burkitt-like lymphoma [BLL])? [If yes, then no further questions.]	Yes	No
2	Does the patient have a diagnosis of one of the following types of cluster of differentiation 20 (CD-20) positive, Central Nervous System (CNS) cancers: A) primary CNS lymphomas, B) leptomeningeal metastases from lymphomas? [If yes, then no further questions.]	Yes	No
3	Does the patient have a diagnosis of any of the following cluster of differentiation 20 (CD20)-positive hematologic malignancies: A) Pediatric mature B-cell acute leukemia (B-AL), B) Hodgkin's lymphoma (nodular lymphocyte-predominant), C) acute lymphoblastic leukemia, D) Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma, E) Rosai-	Yes	No

	Dorfman disease? [If yes, then no further questions.]		
4	Does the patient have a diagnosis of any of the following: A) chronic graft-versus-host disease, B) autoimmune hemolytic anemia, C) refractory immune or idiopathic thrombocytopenic purpura (ITP), D) Sjogren syndrome, E) thrombotic thrombocytopenic purpura (TTP), F) prevention of Epstein-Barr virus (EBV)-related post-transplant lymphoproliferative disorder (PTLD), G) refractory myasthenia gravis, H) pemphigus vulgaris? [If yes, then no further questions.]	Yes	No
5	Does the patient have a diagnosis of Wegener's granulomatosis (also known as granulomatosis with polyangiitis [GPA]) or microscopic polyangiitis (MPA)? [If no, then skip to question 7.]	Yes	No
6	Will the requested medication be used in combination with glucocorticoids? [No further questions.]	Yes	No
7	Does the patient have a diagnosis of moderately to severely active rheumatoid arthritis? [If no, then skip to question 11.]	Yes	No
8	Is the patient currently receiving therapy with the requested medication for the treatment of rheumatoid arthritis? [If yes, then no further questions.]	Yes	No
9	Will the requested medication be used in combination with methotrexate, unless the patient has an intolerance or contraindication to methotrexate? [If no, then no further questions.]	Yes	No
10	Does the patient meet any of the following criteria: A) the patient has had an inadequate response, intolerance or contraindication to methotrexate, B) the patient has had an inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD? [No further questions.]	Yes	No
11	Does the patient have a diagnosis of relapsing remitting multiple sclerosis? [If no, then skip to question 13.]	Yes	No
12	Has the patient had an inadequate response to two or more disease-modifying drugs indicated for multiple sclerosis despite adequate duration of treatment? [No further questions.]	Yes	No
13	Is the requested medication being prescribed to treat an immune checkpoint inhibitor-related toxicity?	Yes	No

Comments:	

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ Date:_____