HIGHMARK HEALTH OPTIONS

Updated: 01/2025
Approved: 01/2025

Request for Prior Authorization for Rituximab Products
Website Form – www.wv.highmarkhealthoptions.com
Submit request via: Fax - 1-833-547-2030.

All requests for Rituximab Products require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Rituximab products include Rituxan (rituximab), Rituxan Hycela (rituximab and hyaluronidase human), and rituximab biosimilars

Rituximab Product Prior Authorization Criteria:

For all requests, all of the following criteria must be met:

- Medication must be prescribed by or in association with a Hematologist, Oncologist, Immunologist, Ophthalmologist, Neurologist, Dermatologist or Rheumatologist
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- Must be age-appropriate according to FDA-approved labeling, nationally recognized compendia, or evidence-based practice guidelines

Coverage may be provided for oncology indications

- **Initial Duration of Approval:** as requested with a maximum of 12 months
- **Reauthorization criteria:**
  - Documentation that the member had a positive clinical response and is able to tolerate therapy
- **Reauthorization Duration of Approval:** as requested with a maximum of 12 months

Coverage may be provided with a diagnosis of Granulomatosis with Polyangiitis (GPA or Wegener's Granulomatosis) and Microscopic Polyangiitis (MPA) and the following criteria is met:

- Must be used in combination with glucocorticoids.
- **Initial Duration of Approval:** 1 month
- **Reauthorization Criteria:** Improvement with prior courses of treatment.
- **Reauthorization Duration of approval:** 1 month

Coverage may be provided with a diagnosis of Rheumatoid Arthritis and the following criteria is met:

- Member must have a history of trial and failure, contraindication, or intolerance of at least 3 months of treatment with methotrexate or another DMARD**.**
- Member must have a history of trial and failure, contraindication, or intolerance of at least 3 months of treatment with a tumor necrosis factor (TNF) inhibitor.
- Medication will be used in combination with Methotrexate (if not contraindicated or member does not have intolerance to methotrexate).
- **Initial Duration of Approval:** 6 months
- **Reauthorization Criteria:**
  - There must be documented, significant improvement with prior courses of treatment.
- **Reauthorization Duration of approval:** 6 months

Coverage may be provided with a diagnosis of Pemphigus Vulgaris and the following criteria is met:

- Member must have mucosal involvement and diagnosis confirmed by ONE of the following:
  - Lesional skin or mucosal biopsy for routine hematoxylin and eosin (H&E) staining.
  - A perilesional skin or mucosal biopsy for direct immunofluorescence (DIF)
  - Serum collection for enzyme-linked immunosorbent assay (ELISA) and indirect immunofluorescence (DIF)
- **Initial Duration of Approval:** 1 month
- **Reauthorization Criteria**
  - There must be improvement with prior course of treatment.
- **Reauthorization Duration of Approval:** 1 month

Coverage may be provided with a diagnosis of Neuromyelitis Optica (NMO) and the following criteria is met:

- Documentation of at least 1 attack during the last year or at least 2 attacks during the last 2 years
- **Initial Duration of Approval:** 1 month
- **Reauthorization Criteria:**
  - There must be documented, significant improvement with prior courses of treatment.
- **Reauthorization Duration of approval:** 6 months

Coverage may be provided with a diagnosis of Relapsing forms of Multiple Sclerosis (relapsing-remitting, secondary-progressive, or progressive-relapsing multiple sclerosis) and the following criteria is met:

- Member must have a medical history of one of the following:
  - One clinical relapse documented (e.g. functional disability, hospitalization, acute steroid therapy, etc.) during the prior year
  - Two relapses within the prior two years
  - A single clinical demyelinating event and 2 or more brain lesions characteristic of MS
- If coverage is provided for situations in which there is functional status that can be preserved, ONE of the following must be met:
  - Member must still be able to walk at least a few steps
  - Member must have some functional arm/hand use consistent with performing activities of daily living
- Must provide documentation showing the member has tried and failed another MS treatment for at least 90 days
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**
  - Documentation of clinical response defined as:
    - Member continues to receive benefit from treatment by having the ability to walk at least a few steps or alternatively have some functional arm/hand use consistent with performing activities of daily living.
    - Member did not experience 1 or more relapses
    - Member does not have 2 or more unequivocally new MRI-detected lesions

  Reauthorization Duration of approval: 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

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RITUXIMAB PRODUCTS
PRIOR AUTHORIZATION FORM – PAGE 1 OF 2

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (833)-547-2030.**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: 1-844-325-6251 Mon – Fri 8 am to 7 pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	
Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No		

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:
Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:

Rheumatoid Arthritis:
Which of the following have been tried for at least 3 months:
- ☐ Methotrexate or another DMARD
- ☐ TNF Inhibitor

Will the medication be used in combination with methotrexate? ☐ Yes ☐ No

Granulomatosis with Polyangiitis (GPA or Wegener's Granulomatosis) and Microscopic Polyangiitis (MPA):
Will the medication be used in combination with glucocorticoids? ☐ Yes ☐ No

Pemphigus Vulgaris:
How was the diagnosis confirmed? Please check all that apply:
- ☐ Lesional skin or mucosal biopsy for routine hematoxylin and eosin (H&E) staining
- ☐ A perilesional skin or mucosal biopsy for direct immunofluorescence (DIF)
- ☐ Serum collection for enzyme-linked immunosorbent assay (ELISA) and indirect immunofluorescence (DIF)

Neuromyelitis Optica (NMO):
Is the member AQP4-IgG/NMO-IgG positive or negative? ☐ Positive ☐ Negative ☐ Unknown/has not been tested
How many relapses have occurred over the past year? _____
What is the EDSS score? ☐ ≤ 7.0 ☐ > 7.0
If using corticosteroids, what is the daily dose? ☐ ≤ equivalent of prednisone 20 mg ☐ > equivalent of prednisone 20 mg ☐ N/A

Relapsing forms of Multiple Sclerosis:
Which of the following apply?
- ☐ One clinical relapse within the past year
- ☐ Two relapses within the past two years
- ☐ A single clinical demyelinating event and 2 or more brain lesions characteristic of MS

What is the EDSS score? ☐ ≤ 6.5 ☐ > 6.5
Will this be used in combination with other disease modifying therapies for MS? ☐ Yes ☐ No

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RITUXIMAB PRODUCTS
PRIOR AUTHORIZATION FORM – PAGE 2 OF 2

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If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: 1-844-325-6251 Mon – Fri 8 am to 7 pm

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the member experienced an improvement with treatment? ☐ Yes ☐ No

For Neuromyelitis Optica (NMO):
Have there been fewer relapses since starting this treatment? ☐ Yes ☐ No

For relapsing forms of Multiple Sclerosis, has the member experienced any of the following?
- Increase in EDSS score ☐ Yes ☐ No
- 1 or more relapses ☐ Yes ☐ No

2 or more unequivocally new MRI-detected lesions ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date