

## PHARMACY POLICY STATEMENT

### Georgia Medicaid

DRUG NAME	Rituxan (rituximab)
BILLING CODE	J9312
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT—see “Dosage Allowed” sections
LIST OF DIAGNOSES CONSIDERED <b>NOT</b> MEDICALLY NECESSARY	<a href="#">Click Here</a>

Rituxan (rituximab) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

### GRANULOMATOSIS WITH POLYANGIITIS (GPA) (WEGENER’S GRANULOMATOSIS) AND MICROSCOPIC POLYANGIITIS (MPA)

For **initial** authorization:

1. Member is 2 years old or older; AND
2. Medication must be prescribed by or in consultation with a nephrologist or rheumatologist; AND
3. Member has a confirmed diagnosis of severe GPA or MPA, **or** non-severe disease (non-organ threatening, non-life-threatening) refractory to glucocorticoids in combination with methotrexate; AND
4. Rituxan will be initiated in combination with glucocorticoids; AND
5. Member has at least ONE of the following:
  - a) Member’s disease remains active or has progressed despite at least a 3 month trial of glucocorticoids in combination with cyclophosphamide;
  - b) Further treatment with cyclophosphamide would exceed the maximum cumulative dose;
  - c) Cyclophosphamide is contraindicated or not tolerated by the member.
6. **Dosage allowed:** Please refer to the Dosing and Administration section of the package insert.

***If member meets all the requirements listed above, the medication will be approved for 6 months.***

For **reauthorization**:

1. Member tolerates infusions; AND
2. Chart notes demonstrate clinical improvement of disease signs and symptoms.

***If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.***

## PEMPHIGUS VULGARIS (PV)

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Must be prescribed by or in consultation with a dermatologist; AND
3. Member has a documented diagnosis of moderate to severe PV; AND
4. Rituxan will be initiated in combination with a corticosteroid taper (unless contraindicated); AND
5. Member has tried and failed or has contraindication to high dose corticosteroid (equivalent to 1.5mg/kg/day prednisone) and an adjuvant immunosuppressive agent such as azathioprine or mycophenolate mofetil.
6. **Dosage allowed:** Initial: Two 1000mg doses separated by 2 weeks; Maintenance: 500mg infusion at month 12 and every 6 months thereafter or based on clinical evaluation -- no sooner than 16 weeks following the previous infusion; Relapse: 1000mg infusion.

***If member meets all the requirements listed above, the medication will be approved for 12 months.***

For **reauthorization**:

1. Member tolerates infusions; AND
2. Chart notes demonstrate clinical improvement of signs and symptoms (e.g. healed lesions, fewer new lesions, etc.)

***If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.***

## RHEUMATOID ARTHRITIS (RA)

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Medication is being prescribed by or in consultation with a rheumatologist; AND
3. Member has a documented diagnosis of moderately- to severely- active RA; AND
4. Rituxan is being used in combination with methotrexate, unless unable to tolerate; AND
5. Member must have inadequate response or intolerance to one or more tumor necrosis factor (TNF) antagonists (e.g. adalimumab, etanercept, infliximab) for at least 3 months each. Note: TNF antagonists require prior authorization.
6. **Dosage allowed:** Two 1000mg doses separated by 2 weeks; subsequent courses repeated no sooner than every 16 weeks (every 24 weeks is typical).

***If member meets all the requirements listed above, the medication will be approved for 6 months.***

For **reauthorization**:

1. Member tolerates infusions; AND
2. Chart notes demonstrate improvement of RA signs and symptoms (e.g. fewer number of painful and swollen joints, achievement of remission, etc.)

***If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.***

## ACQUIRED THROMBOTIC THROMBOCYTOPENIC PURPURA (aTTP)

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Medication must be prescribed by or in consultation with a hematologist; AND
3. Member has a presumptive or confirmed diagnosis of aTTP including ALL of the following:
  - a) Lab results showing thrombocytopenia (platelet count less than 150,000);
  - b) Microangiopathic hemolytic anemia (MAHA) confirmed by presence of schistocytes on blood smear;
  - c) Documentation of a PLASMIC score between 5 and 7 (intermediate to high risk);<sup>25</sup>

- d) Testing shows an ADAMTS13 activity level less than 10%, OR test has been ordered and results are pending.
4. Member's platelet count has not responded after at least 4 days of plasma exchange and glucocorticoid; AND
5. Rituxan is being used in addition to plasma exchange and glucocorticoid.
6. **Dosage allowed:** 375mg/m<sup>2</sup> once weekly for 4 doses (off label).<sup>26</sup>

***If member meets all the requirements listed above, the medication will be approved for 30 days.***

For **reauthorization**:

1. Member is experiencing a relapse of symptoms (thrombocytopenia and MAHA); AND
2. ADAMTS13 activity is less than 20% (lab report required).

***If member meets all the reauthorization requirements above, the medication will be approved for an additional 30 days.***

## NON-HODGKIN'S LYMPHOMA (NHL)

These requests must be submitted through [NantHealth/Eviti](#) portal.

## CHRONIC LYMPHOCYTIC LEUKEMIA (CLL)

These requests must be submitted through [NantHealth/Eviti](#) portal.

**CareSource considers Rituxan (rituximab) not medically necessary for the treatment of the diseases that are not listed in this document.**

DATE	ACTION/DESCRIPTION
6/9/2020	New policy for Rituxan created.
7/28/2020	Added criteria for aTTP.

### References:

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Effective date: 12/01/2020

Revised date: 07/28/2020