Prescriber Criteria Form Truxima 2025 PA Fax 4710-A v1 010125.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) relapsed, refractory, or non-progressing low-grade, C) diffuse large B-cell lymphoma, D) chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), E) mantle cell lymphoma, F) marginal zone lymphomas (nodal, extranodal, splenic marginal zone lymphoma), G) Burkitt lymphoma, H) high-grade B-cell lymphoma, I) histological transformation from indolent lymphomas to diffuse large B-cell lymphoma, J) histological transformation from CLL/SLL to diffuse large B-cell lymphoma, K) primary cutaneous B-cell lymphoma, L) Castleman disease, M) human immunodeficiency virus (HIV)-related B-cell lymphoma, N) hairy cell leukemia, O) post-transplant lymphoproliferative disorder (PTLD), P) B-cell lymphoblastic lymphoma, Q) pediatric aggressive mature B-cell lymphomas (including Burkitt-like lymphoma [BLL], primary mediastinal large B-cell lymphoma)? [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) Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma, B) Hodgkin's lymphoma (nodular	Yes ◯	No ◯

	lymphocyte-predominant), C) acute lymphoblastic leukemia, D) Rosai-Dorfman disease, E) Pediatric mature B-cell acute leukemia (B-AL)? [If yes, then no further questions.]		
4	Does the patient have a diagnosis of any of the following: A) refractory immune or idiopathic thrombocytopenic purpura (ITP), B) autoimmune hemolytic anemia, C) chronic graft-versus-host disease (GVHD), D) Sjogren syndrome, E) thrombotic thrombocytopenic purpura (TTP), F) refractory myasthenia gravis, G) prevention of Epstein-Barr virus (EBV)-related post-transplant lymphoproliferative disorder (PTLD), H) pemphigus vulgaris (PV)? [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 OR does the patient have 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:_____