Pharmacy Medical Necessity Guidelines: Rituxan® (rituximab)

Effective: February 18, 2019

Prior Authorization Required  √  Type of Review – Care Management
Not Covered  √  Type of Review – Clinical Review

Pharmacy (RX) or Medical (MED) Benefit  MED / RX  Department to Review  PRECERT / MM

These pharmacy medical necessity guidelines apply to the following:

**Commercial Products**
- Tufts Health Plan Commercial products – large group plans
- Tufts Health Plan Commercial products – small group and individual plans
- Tufts Health Freedom Plan products – large group plans
- CareLinkSM – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

**Tufts Health Public Plans Products**
- Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
- Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans
- Tufts Health RITogether – A Rhode Island Medicaid Plan

Fax Numbers:
- All plans except Tufts Health Public Plans
  - PRECERT: 617.972.9409
- Tufts Health Public Plans
  - MM: 888.415.9055

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

**OVERVIEW**

**FOOD AND DRUG ADMINISTRATION-APPROVED INDICATIONS**
Rituxan (rituximab) is a CD20-directed cytolytic antibody indicated for the treatment of adult patients with:

- **Chronic Lymphocytic Leukemia (CLL):**
  In combination with fludarabine and cyclophosphamide (FC, for the treatment of patients with previously untreated and previously treated CD-20 positive CLL.

- **Non-Hodgkin’s Lymphoma (NHL):**
  - Relapsed or refractory, low-grade or follicular, CD20-positive, B-cell NHL as a single agent
  - Previously untreated follicular, CD20-positive, B-cell NHL in combination with first line chemotherapy and, in patients achieving a complete or partial response to Rituxan in combination with chemotherapy, as single-agent maintenance therapy
  - Non-progressing (including stable disease), low-grade, CD20-positive, B-cell NHL as a single agent after first-line CVP chemotherapy
  - Previously untreated diffuse large B-cell, CD20-positive NHL in combination with CHOP or other anthracycline-based chemotherapy regimens

- **Pemphigus Vulgaris (PV)**
  With moderate to severe PV

- **Rheumatoid Arthritis (RA):**
  In combination with methotrexate for the treatment of adult patients with moderately to severely active RA who have had an inadequate response to one or more tumor necrosis factor (TNF) antagonist therapies

- **Wegener’s Granulomatosis (WG) and Microscopic Polyangiitis (MPA)**
  In combination with glucocorticoids for the treatment of adult patients with WG and MPA
COVERAGE GUIDELINES

**Chronic Lymphocytic Leukemia (CLL) and Non-Hodgkin’s Lymphoma (NHL)**

The plan does **NOT** require prior authorization for coverage of Rituxan (rituximab) for the treatment of NHL or CLL for claims billed under the medical benefit.

- **ICD-10 Codes (effective on or after October 1, 2015)**
  - For any medical billing claim submitted, please utilize ICD-10 codes C82.00 – C83.99, C84.60 – 86.6, C08.4, C91.10 – C91.12 or C96.4 – C96.5 as the primary diagnosis codes when using Rituxan (rituximab) for the treatment of NHL or CLL.

- **ICD-9 Codes**
  - For any medical billing claim submitted, please utilize ICD-9 codes 200.00 – 200.88 (lymphosarcoma and reticulosarcoma and other specified malignant tumors), 202.00 – 202.08 (nodular lymphoma), 202.80 – 202.88 (Non-Hodgkin’s type NEC), or 204.10 – 204.12 (chronic lymphoid/lymphocytic leukemia) as the primary diagnosis codes when using Rituxan (rituximab) for the treatment of NHL or CLL.

- **Tufts Health Together only:**
  - For Members who obtain Rituxan (rituximab) via their pharmacy benefit for the treatment of NHL or CLL, a prior authorization request must be submitted to the plan indicating the diagnosis. Requests will be approved if submitted for the ICD codes indicated above.

The plan may authorize coverage of Rituxan (rituximab) for Members when all of the following criteria are met:

**Pemphigus vulgaris (PV)**
1. Documented diagnosis of moderate to severe pemphigus vulgaris **AND**
2. The prescribing physician is a dermatologist **AND**
3. Documentation the Member has demonstrated an inadequate response to or the prescribing physician indicates clinical inappropriateness of systemic glucocorticoids

**Rheumatoid Arthritis (RA)**
1. Documented diagnosis of rheumatoid arthritis **AND**
2. The prescribing physician is a rheumatologist **AND**
3. Documentation the Member has demonstrated an inadequate response to an appropriate trial with ≥1 tumor necrosis factor (TNF) antagonist therapy (Cimzia, Enbrel, Humira, Remicade, or Simponi/Simponi Aria) **AND**
4. Documentation the Member is concurrently taking methotrexate

**Wegener’s Granulomatosis (WG) and Microscopic Polyangiitis (MPA)**
1. Documented diagnosis of ANCA including Wegener’s granulomatosis or microscopic polyangiitis **AND**
2. The prescribing physician is a rheumatologist **AND**
3. Documentation the Member is concurrently taking glucocorticoids (e.g., prednisone)

**Multiple Sclerosis - Primary-Progressive, Relapsing-Remitting, and Secondary-Progressive**

- **Multiple Sclerosis (off-label)**
  1. Documented diagnosis of one of the following:
     a) Primary-progressive multiple sclerosis
     b) Relapsing-remitting multiple sclerosis
     c) Secondary-progressive multiple sclerosis **AND**
  2. The prescribing physician is a neurologist with expertise in treating multiple sclerosis
Off-label Use Coverage for Other Cancer Diagnoses

Coverage for other cancer diagnoses may be authorized provided effective treatment with such drug is recognized for treatment of such indication in one of the standard reference compendia, or in the medical literature, or by the Massachusetts commissioner of Insurance (commissioner) under the provisions of the "Sullivan Law": (M.G.L. c.175, s.47K ).

The plan may authorize coverage for use for other cancer diagnoses provided effective treatment with such drug is recognized as a "Medically Accepted Indication" according to the National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium as indicated by a Category 1 or 2A for quality of evidence and level of consensus.

**Note:** The plan requires prescribers to submit clinical documentation supporting the drug’s effectiveness in treating the intended malignancy, including the applicable NCCN guideline(s).

In cases where the requested off-label use for the diagnosis is not recognized by the NCCN Drugs and Biologics Compendium, The plan will follow the Centers for Medicare and Medicaid Services (CMS) guidance, unless otherwise directed by the commissioner, and accept clinical documentation referenced in one of the other “Standard Reference Compendia” noted below or supported by clinical research that appears in a regular edition of a "Peer-Reviewed Medical Literature" noted below.

"Standard Reference Compendia"
1. American Hospital Formulary Service – Drug Information (AHFS-DI)
2. Thomson Micromedex DrugDex
3. Clinical Pharmacology (Gold Standard)
4. Wolters Kluwer Lexi-Drugs

"Peer Reviewed Medical Literature"

- American Journal of Medicine
- Annals of Internal Medicine
- Annals of Oncology
- Annals of Surgical Oncology
- Biology of Blood and Marrow Transplantation
- Blood
- Bone Marrow Transplantation
- British Journal of Cancer
- British Journal of Hematology
- British Medical Journal
- Cancer
- Clinical Cancer Research
- Drugs
- European Journal of Cancer (formerly the European Journal of Cancer and Clinical Oncology)
- Gynecologic Oncology
- International Journal of Radiation, Oncology, Biology, and Physics
- The Journal of the American Medical Association
- Journal of Clinical Oncology
- Journal of the National Cancer Institute
- Journal of the National Comprehensive Cancer Network (NCCN)
- Journal of Urology
- Lancet
- Lancet Oncology
- Leukemia
- The New England Journal of Medicine
- Radiation Oncology

When the plan evaluates the evidence in published, peer-reviewed medical literature, consideration will be given to the following:
1. Whether the clinical characteristics of the beneficiary and the cancer are adequately represented in the published evidence.
2. Whether the administered chemotherapy regimen is adequately represented in the published evidence.
3. Whether the reported study outcomes represent clinically meaningful outcomes experienced by patients.
4. Whether the study is appropriate to address the clinical question.
   a. whether the experimental design, in light of the drugs and conditions under investigation, is appropriate to address the investigative question (e.g., in some clinical studies, it may be unnecessary or not feasible to use randomization, double blind trials, placebos, or crossover);
   b. that non-randomized clinical trials with a significant number of subjects may be a basis for supportive clinical evidence for determining accepted uses of drugs; and,
   c. that case reports are generally considered uncontrolled and anecdotal information and do not provide adequate supportive clinical evidence for determining accepted uses of drugs.
LIMITATIONS

- The plan will not authorize the use of Rituxan (rituximab) for conditions other than those listed above without appropriate documentation.
- Initial authorization of Rituxan (rituximab) for ANCA including Wegener’s granulomatosis or microscopic polyangiitis will be limited to 6 months. Additional authorization may be given if documentation of an objective measurable effect is provided indicating clinical improvement of condition. Subsequent authorizations may be given in 6 month intervals.
- Initial authorization of Rituxan (rituximab) for multiple sclerosis, including primary-progressive, relapsing-remitting and secondary-progressive, will be limited to 6 months. Additional authorization may be given if documentation of an objective measurable effect is provided indicating clinical improvement of condition. Subsequent authorizations may be given in 12 month intervals.

CODES

The following HCPCS/CPT code(s) are:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>J9310</td>
<td>Injection, rituximab, 100 mg</td>
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REFERENCES


**APPROVAL HISTORY**
May 9, 2006: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:
3. November 11, 2008: Added ICD-9 diagnoses codes 204.10 – 204.12 (chronic lymphoid/lymphocytic leukemia) to criteria #1 for Non-Hodgkin’s Lymphoma.
5. November 10, 2009: Added Cimzia (certolizumab pegol) and Simponi (golimumab) to tumor necrosis factor (TNF) antagonist therapy prerequisites for rheumatoid arthritis.
6. January 1, 2010: Removal of Tufts Health Plan Medicare Preferred language (separate criteria have been created specifically for Tufts Health Plan Medicare Preferred).
7. May 11, 2010: Added approval for Chronic Lymphocytic Leukemia and updated pharmacy coverage guidelines.
9. January 11, 2011: Administrative Update: Effective 4/1/2011, Off-label Use Coverage for Other Cancer Diagnoses language updated. The plan requires prescribers to submit clinical documentation supporting the drug’s effectiveness in treating the intended malignancy, including the applicable NCCN guideline(s).
12. October 9, 2012: Added ICD-9 diagnoses codes 202.00 – 202.08 (nodular lymphoma) to criterion #1.
15. September 9, 2014: No changes
16. September 16, 2015: No changes
17. January 1, 2016: Administrative change to rebranded template.
18. April 12, 2016: Effective 10/1/2016, MNG applies to Tufts Health Together.
19. May 10, 2016: Clarified that for Tufts Health Together Members who are obtaining Rituxan (rituximab) via their pharmacy benefit, a prior authorization request must be submitted to the plan. Added ANCA to diagnoses for Wegener’s granulomatosis and microscopic polyangiitis.
20. August 9, 2016: Effective 10/1/2016, added coverage criteria and limitations for the off-label diagnosis of multiple sclerosis. Moved limitations for ANCA indications to the Limitations section.
22. August 8, 2017: Added information about the coverage of newly approved Rituxan Hycela to the Medical Necessity Guideline.

**BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION**
Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the
individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.