Pharmacy Medical Necessity Guidelines: Rituximab Products: Rituxan®, Rituxan Hycela®, Ruxience®, Truxima®

Effective: October 1, 2020

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
☒ Tufts Health Freedom Plan products – small group plans
- CareLink℠ – 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

Rituximab is a CD20-directed cytolytic antibody indicated for the treatment the following types of cancers:

- **Chronic Lymphocytic Leukemia (CLL)**
  In combination with fludarabine and cyclophosphamide, for the treatment of adult patients with previously untreated and previously treated CD-20 positive CLL.
- **Granulomatosis with Polyangiitis (GPA) (Wegener's Granulomatosis) and Microscopic Polyangiitis (MPA)**
  In combination with glucocorticoids for the treatment of adult patients with WG and MPA
- **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 cyclophosphamide, vincristine, and prednisone (CVP) chemotherapy
  - Previously untreated diffuse large B-cell, CD20-positive NHL in combination with cyclophosphamide, doxorubicin, vincristine, prednisone (CHOP) or other anthracycline-based chemotherapy regimens
- **Pemphigus Vulgaris (PV)**
  Treatment of adult patients 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

Rituximab is also available in combination with hyaluronidase indicated for the treatment of CLL, follicular lymphoma (FL), and diffuse large B-cell lymphoma (DLBCL). Rituximab/hyaluronidase is not indicated for the treatment of non-malignant conditions and is administered via subcutaneous injection. Treatment should be initiated only after patients have received at least one full dose of a rituximab product by intravenous infusion.

Available rituximab biosimilars include Ruxience (rituximab-pvvr) and Truxima (rituximab-abbs).

COVERAGE GUIDELINES

Malignant Conditions

Note: The plan does **NOT** require prior authorization for coverage of Ruxience (rituximab-pvvr) or Truxima (rituximab-abbs) for the treatment of CLL and NHL for claims billed under the medical benefit. For any medical billing claim submitted, utilize the ICD-10 codes C82.00-C83.99, C84.60-C86.6, C88.4, C91.10-C91.12, C96.4-C96.5 as the primary diagnosis codes.

Note: For Tufts Health Together Members who obtain a rituximab biosimilar via the pharmacy benefit for the treatment of cancer, 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.

Rituxan (rituximab) and Rituxan Hycela (rituximab/hyaluronidase human)

The plan may authorize coverage of Rituxan (rituximab) or Rtixuan Hycela (rituximab/hyaluronidase human) for the treatment of ANY malignant condition when all of the following criteria are met:

1. Documented previous failure of or clinical inappropriateness with a rituximab biosimilar

Non-malignant Conditions

The plan may authorize coverage of rituximab products when all of the following criteria are met:

Note: See additional coverage criteria for Rituxan (rituximab) below

Granulomatosis with Polyangiitis (GPA) (Wegener's Granulomatosis) and Microscopic Polyangiitis (MPA)

1. Documented diagnosis of granulomatosis with polyangiitis (Wegener's granulomatosis) or microscopic polyangiitis

AND

2. The prescribing physician is a rheumatologist or a nephrologist

AND

3. Documentation the Member is concurrently taking glucocorticoids (e.g., prednisone)

Pemphigus vulgaris (PV)

1. Documented diagnosis of moderate to severe pemphigus vulgaris (PV)

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 (RA)

AND

2. The prescribing physician is a rheumatologist

AND

3. Documentation the Member has demonstrated an inadequate response to an appropriate trial with at least one of the following: Enbrel, Humira, Remicade, or Simponi/Simponi Aria

AND

4. Documentation the Member is concurrently taking methotrexate

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

Rituxan (rituximab)
In addition to the coverage criteria for non-malignant conditions above, the plan may authorize coverage of Rituxan (rituximab) when all of the following criteria are met:
1. Documented previous failure of or clinical inappropriate a rituximab biosimilar

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

- Coverage of Rituxan (rituximab) or Rituxan Hycela (rituximab/hyaluronidase human) will be authorized for any FDA-approved indication that available biosimilars do not share.
- Documentation of any previous use of Rituxan (rituximab) or Rituxan Hycela (rituximab/hyaluronidase human) does not qualify as a clinically appropriate reason to not prescribe available biosimilars.
- The plan will not authorize the use of rituximab products included in the Medical Necessity Guideline for conditions other than those listed above without appropriate documentation.
- Authorizations for Rituxan (rituximab) and Rituxan Hycela (rituximab/hyaluronidase human) will be provided for 12 months.

CODES

The following HCPCS/CPT code(s) are:

Code	Description
J9311	Injection, rituximab 10 mg and hyaluronidase
J9312	Injection, rituximab, 10 mg
Q5115	Injection, rituximab-abbs, biosimilar (Truxima), 10 mg
Q5119	Injection, rituximab-pvvr, biosimilar (RUXIENCE), 10 mg

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APPROVAL HISTORY

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

Subsequent endorsement date(s) and changes made:

1. May 8, 2007: No changes.
2. March 4, 2008: Added ICD-9 diagnoses codes 200.00 – 200.80 to criteria #1 for Non-Hodgkin's Lymphoma.
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.
4. January 13, 2009: Removed Section B and inserted updated language for Off-label Use Coverage for Other Cancer Diagnoses.
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.
8. September 14, 2010: Added ICD-9 diagnoses codes 200.81 – 200.88 to criteria #1 for Non-Hodgkin's Lymphoma.
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).
10. May 10, 2011: Added coverage guidelines for the treatment of Wegener's granulomatosis and microscopic polyangiitis.
11. May 8, 2012: No changes.
12. October 9, 2012: Added ICD-9 diagnoses codes 202.00 – 202.08 (nodular lymphoma) to criterion #1.
13. September 10, 2013: No changes.
14. October 11, 2013: Administrative update: Added ICD-10 codes to policy.
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.
21. April 11, 2017: Administrative update. Effective 6/1/2017, Medical Necessity Guideline applies to Tufts Health RITogether.
22. August 8, 2017: Added information about the coverage of newly approved Rituxan Hycela to the Medical Necessity Guideline.

23. August 7, 2018: Updated coverage criteria for off-label use in multiple sclerosis to allow for first line use in primary-progressive, relapse-remitting, or secondary-progressive multiple sclerosis when prescribed by a neurologist with expertise in treating multiple sclerosis.
24. February 12, 2019: Administrative update: Removed Rituxan Hycela from Medical Necessity Guideline because no prior authorization required. Added coverage criteria for new supplemental indication of pemphigus vulgaris.
25. January 14, 2020: Effective April 1, 2020, changed the name of the Medical Necessity Guideline to "Rituximab products: Rituxan®, Rituxan Hycela®, Truxima®" and added Rituxan Hycela and Truxima to the Medical Necessity Guideline. Added step through rituximab biosimilars for Rituxan and Rituxan Hycela. Added a nephrologist to the provider specialties approvable for Granulomatosis with Polyangiitis and Microscopic Polyangiitis.
26. April 14, 2020: Added Q code (Q5115) and Ruxience (rituximab-pvvr) to the Medical Necessity Guideline. Removed limited duration of approval rules for multiple sclerosis and ANCA including Wegener's granulomatosis or microscopic polyangiitis. Changed the name of the Medical Necessity Guideline to "Rituximab products: Rituxan, Ruxience, and Truxima." Delayed the implementation date of step through rituximab biosimilars for Rituxan and Rituxan Hycela and updated duration of authorizations for Rituxan and Rituxan Hycela to be 12 months for all requests to July 1, 2020.
27. July 1, 2020: Administrative update: Added new Q code Q5119 to Medical Necessity Guideline.
28. July 14, 2020: Delayed the implementation date of step through rituximab biosimilars for Rituxan and Rituxan Hycela and updated duration of authorizations for Rituxan and Rituxan Hycela to be 12 months for all requests to October 1, 2020.

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.