Clinical Policy: Rituximab (Rituxan), Rituximab-arrx (Riabni), Rituximab-pvvr (Ruxience), Rituximab-abbs (Truxima), Rituximab-Hyaluronidase (Rituxan Hycela)

Reference Number: AZ.CP.PHAR.260
Effective Date: 04.15.20
Last Review Date: 08.23
Line of Business: Arizona Medicaid (AzCH-CCP and Care1st)

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Rituximab (Rituxan®) and its biosimilars [rituximab-arrx (Riabni™), rituximab-pvvr (Ruxience™), rituximab-abbs (Truxima®)] are CD20-directed cytolytic antibodies.

Rituximab and hyaluronidase (Rituxan Hycela™) is a combination of rituximab and human hyaluronidase that is used to increase the dispersion and absorption of the co-administered drugs when given subcutaneously.

AHCCCS preferred drugs in this class include Riabni™ (rituximab-arrx), Ruxience™ (rituximab-pvvr), Truxima® (rituximab-abbs).

AHCCCS non-preferred drugs in this class include and Rituxan® (rituximab), Rituxan Hycela™ (rituximab and hyaluronidase).

FDA Approved Indication(s)

Indications		Rituxan	Riabni	Ruxience	Truxima	Rituxan Hycela*
	Oncology indications (for adults unless otherwise indicated)					
Low-grade and follicular B-cell NHL	Relapsed or refractory, low-grade *[Rituxan, Riabni, Ruxience, Truxima]* or follicular *[Rituxan, Riabni, Ruxience, Truxima, Rituxan Hycela]*, CD20-positive, B-cell NHL as a single agent	X	X	X	X	X
	Previously untreated follicular, CD20-positive B-cell NHL in combination with first-line chemotherapy and, in patients achieving a complete or partial response to a rituximab product in combination with chemotherapy, as single-agent maintenance therapy	X	X	X	X	X

CLINICAL POLICY
Rituximab, Rituximab-arrx, Rituximab-pvvr, Rituximab-abbs, Rituximab-Hyaluronidase

Indications		Rituxan	Riabni	Ruxience	Truxima	Rituxan Hycela*
	Non-progressing (including stable disease), low-grade *[Rituxan, Riabni, Ruxience, Truxima]* or follicular *[Rituxan Hycela],* CD20-positive B-cell NHL as a single agent after first-line CVP chemotherapy	X	X	X	X	X
DLBCL *(a B-cell NHL)*	Previously untreated CD20-positive DLBCL in combination with CHOP or other anthracycline-based chemotherapy regimens	X	X	X	X	X
CLL *(a B-cell NHL)*	Previously untreated and treated CD20-positive CLL in combination with FC chemotherapy	X	X	X	X	X
Pediatric B-cell NHL and B-cell acute leukemia	Previously untreated, advanced stage, CD20-positive, DLBCL, Burkitt lymphoma (BL), Burkitt-like lymphoma (BLL) or mature B-cell acute leukemia (B-AL) in combination with chemotherapy	X (6 months and older)				
	Non-oncology indications (for adults unless otherwise indicated)					
RA	Moderately to severely active RA in combination with MTX in patients who have inadequate response to one or more TNF antagonist therapies	X	X	X	X	
GPA, MPA	GPA and MPA in combination with glucocorticoids	X (2 years and older)	X	X	X	
PV	Moderate to severe PV	X				

Abbreviations: B-AL (B-cell acute leukemia), BL (Burkitt lymphoma), BLL (Burkitt-like lymphoma), CLL (chronic lymphocytic leukemia), DLBCL (diffuse large B-cell lymphoma), GPA (granulomatosis with polyangiitis; Wegener`s granulomatosis), MPA (microscopic polyangiitis), NHL (Non-Hodgkin's lymphoma), PV (pemphigus vulgaris), RA (rheumatoid arthritis).

**Rituxan Hycela limitations of use: 1) Initiate treatment with Rituxan Hycela only after patients have received at least one full dose of a rituximab product by intravenous infusion; 2) Rituxan Hycela is not indicated for the treatment of non-malignant conditions.*

CLINICAL POLICY
Rituximab, Rituximab-arrx, Rituximab-pvvr, Rituximab-abbs, Rituximab-Hyaluronidase

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of Arizona Complete Health-Complete Care Plan and Care1st that Rituxan, Riabni, Ruxience, Truxima, and Rituxan Hycela are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. B-Cell Lymphomas *(includes CLL)* (must meet all)**:**

1. Diagnosis of any of the following non-Hodgkin's lymphoma (NHL) subtypes (a-n):
   a. AIDS-related B-cell lymphomas;
   b. B-cell acute leukemia (B-AL);
   c. Burkitt lymphoma or Burkitt-like lymphoma (BLL);
   d. Castleman's disease;
   e. Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)
   f. Diffuse large B-cell lymphoma (DLBCL);
   g. Follicular lymphoma (FL);
   h. Hairy cell leukemia (Rituxan/Riabni/Ruxience/Truxima only);
   i. Low- or high-grade B-cell lymphoma;
   j. MALT lymphoma (gastric or nongastric);
   k. Mantle cell lymphoma;
   l. Marginal zone lymphoma (nodal or splenic);
   m. Post-transplant lymphoproliferative disorder;
   n. Primary cutaneous B-cell lymphoma;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Member meets one of the following (a or b):
   a. Age ≥ 18 years;
   b. Age < 18 years with mature B-cell lymphoma;
4. If request is for Rituxan Hycela, member has received at least one full dose of Rituxan, Riabni, Ruxience, or Truxima;
5. If request is for Rituxan, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated: Riabni, Ruxience and Truxima;
   **Prior authorization is required*
6. Member does not have combination use of biological disease-modifying antirheumatic drugs or JAK inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
7. Request meets either of the following (a or b):*
   a. Dose does not exceed the number of cycles as indicated in *Section V* and the following per administration (i or ii):

i. Rituxan/Riabni/Ruxience/Truxima: 500 mg/m^2 per IV infusion (*see Section V for cycle regimens)*;
ii. Rituxan Hycela: 1,600 mg/26,800 units per SC injection (*see Section V for cycle regimens)*;

b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration: 6 months

B. Rheumatoid Arthritis (must meet all)**:**

1. Diagnosis of RA per American College of Rheumatology (ACR) criteria (*see Appendix E*);
2. Request is for Rituxan/Riabni/Ruxience/Truxima;
3. Prescribed by or in consultation with a rheumatologist;
4. Age ≥ 18 years;
5. History of failure to one non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at maximally indicated doses within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial and claims history must be verified):
6. Failure of a trial of THREE of the following, each used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated (a, b, c, d. or e):
   a. **Avsola**;
   b. **Enbrel**;
   c. **Humira**;
   d. If member has not responded or is intolerant to one or more TNF blockers, **Xeljanz immediate-release**, unless member has cardiovascular risk and benefits do not outweigh the risk of treatment;
   e. **Orencia (Autoinjector and Syringe only);**

   **Prior authorization is required for Avsola, Enbrel, Humira, Orencia, and Xeljanz immediate-release*
7. If request is for Rituxan, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated: Riabni, Ruxience and Truxima;
8. Rituxan/Riabni/Ruxience/Truxima will be administered in combination with MTX unless contraindicated or clinically significant adverse effects are experienced;
9. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
10. Dose does not exceed two-1,000 mg IV infusions separated by 2 weeks followed by two-1,000 mg IV infusions every 16 weeks.

Approval duration: 6 months

C. Granulomatosis with Polyangiitis (Wegener's Granulomatosis) and Microscopic Polyangiitis (must meet all)**:**
1. Diagnosis of GPA or MPA;
2. Request is for Rituxan/Riabni/Ruxience/Truxima;
3. Prescribed by or in consultation with a rheumatologist;
4. For Rituxan: age ≥ 2 years;
5. For age ≥ 18 years if request is for Rituxan, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated: Riabni, Ruxience and Truxima;
   **Prior authorization is required*
6. Prescribed in combination with a glucocorticoid (e.g. prednisone, prednisolone, dexamethasone);
7. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
8. Dose does not exceed (a or b):
   a. Induction: 375 mg/m^2 weekly for 4 weeks;
   b. Follow up treatment: two-500 mg infusions separated by 2 weeks, then 500 mg every 6 months.

Approval duration: 6 months

D. Pemphigus Vulgaris and Pemphigus Foliaceus (must meet all)**:**
1. Diagnosis of PV or pemphigus foliaceus (PF);
2. Request is for Rituxan/Riabni/Ruxience/Truxima;
3. Prescribed by or in consultation with a dermatologist;
4. Age ≥ 18 years;
5. If request is for Rituxan, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated: Riabni, Ruxience and Truxima;
   **Prior authorization is required*
6. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
7. Dose does not exceed (a or b):
   a. Initial: two-1,000 mg infusions separated by 2 weeks;
   b. Maintenance: 500 mg every 6 months (starting 12 months after initial dose).

Approval duration: 6 months

E. NCCN Compendium Indications (off-label) (must meet all)**:**
1. Diagnosis of any of the following (a-h):
   a. Acute lymphoblastic leukemia in patients who are CD20-positive;

   b. Immune checkpoint inhibitor-related toxicities;
   c. Steroid refractory graft-versus-host disease;
   d. Leptomeningeal metastases from lymphoma;
   e. Nodular lymphocyte-predominant Hodgkin lymphoma;
   f. Primary CNS lymphoma;
   g. Rosai-Dorfman disease;
   h. Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma;
2. Request is for Rituxan/Riabni/Ruxience/Truxima;
3. Prescribed by or in consultation with an oncologist or hematologist;
4. Age ≥ 18 years;
5. If request is for Rituxan, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated: Riabni, Ruxience and Truxima;
   **Prior authorization is required*
6. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
7. Dose is within FDA maximum limit for any FDA-approved indication or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 6 months

F. Neuromyelitis Optica Spectrum Disorder (off-label) (must meet all)**:**
1. Diagnosis of neuromyelitis optica spectrum disorder (NMOSD);
2. Request is for Rituxan/Riabni/Ruxience/Truxima;
3. Prescribed by or in in consultation with a neurologist;
4. Age ≥ 18 years;
5. Member has experienced at least one relapse within the previous 12 months;
6. Diagnosis of multiple sclerosis or other diagnoses have been ruled out;
7. If request is for Rituxan, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated: Riabni, Ruxience and Truxima;
   **Prior authorization is required*
8. Rituxan/Riabni/Ruxience/Truxima is not prescribed concurrently with Soliris®, Enspryng™, or Uplizna®;
9. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
10. Request meets one of the following (a, b, or c):
    a. Dose does not exceed 375 mg/m^2 per week for 4 weeks as induction, followed by 375 mg/m^2 biweekly every 6 to 12 months;
    b. Dose does not exceed 1,000 mg biweekly every 6 to 12 months;

c. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence).*

Approval duration: 6 months

G. Immune Thrombocytopenia (off-label) (must meet all)**:**

1. Diagnosis of immune thrombocytopenia (ITP);
2. Request is for Rituxan/Riabni/Ruxience/Truxima;
3. Prescribed by or in consultation with a hematologist;
4. Current (within 30 days) platelet count is < 30,000/µL or member has an active bleed;
5. Member meets one of the following (a or b):
   a. Failure of a systemic corticosteroid;
   b. Member has intolerance or contraindication to systemic corticosteroids, and failure of an immune globulin, unless contraindicated or clinically significant adverse effects are experienced (*see Appendix B*);

   **Prior authorization may be required for immune globulins*
6. If request is for Rituxan, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated: Riabni, Ruxience and Truxima;

   **Prior authorization is required*
7. Rituxan/Riabni/Ruxience/Truxima is not prescribed concurrently with a thrombopoietin receptor agonist (e.g., Nplate®, Promacta®, Doptelet®);
8. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
9. Request meets one of the following (a, b, or c):
   a. Dose does not exceed 375 mg/m^2 per week for 4 weeks;
   b. Dose does not exceed 1,000 mg on days 1 and 15;
   c. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 1 month

H. Dermatomyositis (off-label) (must meet all):

1. Diagnosis of dermatomyositis (DM);
2. Request is for Rituxan/Riabni/Ruxience/Truxima;
3. Prescribed by or in consulation with a dermatologist, rheumatologist, neurologist, or neuromuscular specialist;
4. Failure of a 4-month trial of a systemic corticosteroid (e.g. prednisone) in combination with one of the following immunosuppressive agents, both at up to maximally indicated doses unless clinically significant adverse effects are experienced or all are contraindicated: methoxtrexate, azathioprine, cyclophosphamide, mycophenolate mofetil, tacrolimus, cyclosporine (*see Appendix D*);

5. If request is for Rituxan, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated: Riabni, Ruxience and Truxima;
   **Prior authorization is required*
6. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
7. Request meets one of the following (a or b):
   a. Dose does not exceed both of the following (i and ii):
      i. Initial 1,000 mg/m2 IV infusion;
      ii. Followed by another 1,000 mg/m2 dose given two weeks after the initial dose;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 1 month

I. Nephrotic Syndrome (off-label) (must meet all)**:**

1. Diagnosis of nephrotic syndrome (NS) associated with one of the following (a - f):
   a. Idiopathic membranous nephropathy (IMN);
   b. Focal segmental glomerulosclerosis;
   c. Minimal change disease (MCD);
   d. Membranoproliferative glomerulonephritis;
   e. Lupus nephritis;
   f. IgA nephropathy;
2. Request is for Rituxan/Riabni/Ruxience/Truxima;
3. Prescribed by or in consulation with a nephrologist;
4. Failure of oral corticosteroid therapy, unless contraindicated or clinically significant adverse effects are experienced;
5. Failure of one of the following immunosuppressant agents, unless clinically significant adverse effects are experienced or all are contraindicated: cyclophosphamide, chlorambucil, tacrolimus, cyclosporine, mycophenolate mofetil;
6. If request is for Rituxan, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated: Riabni, Ruxience and Truxima
   **Prior authorization is required*
7. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
8. Request meets one of the following (a or b):
   a. Dose does not exceed 375 mg/m^2 IV infusion once weekly up to 4 doses;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 1 month

J. Autoimmune Hemolytic Anemia (off-label) (must meet all)**:**
1. Diagnosis of one of the following autoimmune hemolytic anemias (AIHA) (a or b):
   a. Warm autoimmune hemolytic anemia (WAIHA);
   b. Cold agglutinin disease (CAD);
2. Request is for Rituxan/Riabni/Ruxience/Truxima;
3. Prescribed by or in consultation with a hematologist;
4. If diagnosis is WAIHA, failure of a systemic glucocorticoid (e.g., prednisone) for ≥ 2 weeks, unless contraindicated or clinically significant adverse effects are experienced;
5. If request is for Rituxan, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated: Riabni, Ruxience and Truxima*;*
   **Prior authorization is required*
6. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
7. Request meets one of the following (a, b, or c):
   a. Dose does not exceed 375 mg/m^2 once weekly for 4 weeks;
   b. Dose does not exceed 1,000 mg on days 1 and 15;
   c. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 1 month

K. Other diagnoses/indications
1. Members with the following diagnoses may be covered if the off-label criteria policy is met: Myasthenia gravis;
2. If request is for Rituxan, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated: Riabni, Ruxience and Truxima;
3. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): AZ.CP.PMN.53 for Arizona Medicaid.

II. Continued Approval

A. Immune Thrombocytopenia (off-label)**:**
1. Re-authorization is not permitted. Members must meet the initial approval criteria.

Approval duration: Not applicable

B. All Other Indications in Section I (must meet all)**:**
1. Member meets one of the following (a or b):

   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Documentation supports that member is currently receiving Rituxan, Riabni, Ruxience, Truxima, or Rituxan Hycela for a covered oncology or rheumatoid arthritis indication as documented by claims history or medical records (document drug, date, and duration of therapy);
2. Meets one of the following (a, b, c, or d):
   a. For NMOSD: Member is responding positively to therapy – including but not limited to improvement or stabilization in any of the following parameters:
      i. Frequency of relapses;
      ii. EDSS score;
      iii. Visual acuity;
   b. For PV or PF: Member is responding positively to therapy, or member has experienced relapse;
   c. For DM (both i and ii):
      i. Provider documentation that states member has continual resistant DM after receiving initial rituximab dose and is previously or currently resistant to a systemic corticosteroid in combination with one of the following immunosuppressive agents, both at up to maximally indicated doses unless clinically significant adverse effects are experienced or all are contraindicated: methoxtrexate, azathioprine, cyclophosphamide, mycophenolate mofetil, tacrolimus, cyclosporine *(see Appendix D)*;
      ii. Request for proceeding dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence);*
   d. For all other indications: Member is responding positively to therapy;
3. If request is for Rituxan, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated: Riabni, Ruxience and Truxima;
   **Prior authorization is required*
4. For NMOSD: Rituxan/Riabni/Ruxience/Truxima is not prescribed concurrently with Soliris®, Enspryng™, or Uplizna®;
5. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
6. If request is for a dose increase, request meets either of the following (a or b):*
   a. New dose does not exceed the following:
      i. NHL:
         a) Rituxan/Riabni/Ruxience/Truxima: 500 mg/m^2 per IV infusion;
         b) Rituxan Hycela: 1,600 mg/26,800 units per SC injection;

ii. RA (Rituxan/Riabni/Ruxience/Truxima): two-1,000 mg IV infusions every 16 weeks;
iii. GPA/MPA (Rituxan/Riabni/Ruxience/Truxima):
  a) Induction: 375 mg/m^2 IV weekly for up to 4 weeks total;
  b) Follow-up treatment: two-500 mg IV infusions separated by two weeks, then 500 mg IV every 6 months;
iv. PV or PF (Rituxan/Riabni/Ruxience/Truxima) (a or b):
  a) Maintenance: 500 mg IV every 6 months (starting 12 months after initial dose);
  b) Relapse: 1,000 mg IV once then 500 mg IV 16 weeks later, then 500 mg IV every 6 months;
v. NMOSD (Rituxan/Riabni/Ruxience/Truxima): 375 mg/m^2 or 1,000 mg biweekly every 6 to 12 months;
vi. DM (both a and b):
  a) Initial 1,000 mg/m2 IV infusion;
  b) Followed by another 1,000 mg/m2 dose given two weeks after the initial dose;
vii. NS (Rituxan/Riabni/Ruxience/Truxima): 375 mg/m^2 IV infusion once weekly up to 4 doses;
viii. AIHA (Rituxan/Riabni/Ruxience/Truxima) (1 or 2):
  1) 375 mg/m^2 once weekly for 4 weeks;
  2) 1,000 mg on days 1 and 15

b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

DM, NS – 1 month
All other indications – 12 months

C. Other diagnoses/indications (must meet all):
1. If request is for Rituxan, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated: Riabni, Ruxience and Truxima;
2. Member meets one of the following (a, b, or c):
   a. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
   b. Members with the following diagnoses may be covered if the off-label criteria policy is met: Myasthenia gravis;
   c. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): AZ.CP.PMN.53 for Arizona Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – AZ.CP.PMN.53 for Arizona Medicaid or evidence of coverage documents;

B. Combination use with biological disease-modifying antirheumatic drugs (bDMARDs) or potent immunosuppressants, including but not limited to any tumor necrosis factor (TNF) antagonists [e.g., Cimzia®, Enbrel®, Humira®, Simponi®, Avsola™, Inflectra™, Remicade®, Renflexis™], interleukin agents [e.g., Arcalyst® (IL-1 blocker), Ilaris® (IL-1 blocker), Kineret® (IL-1RA), Actemra® (IL-6RA), Kevzara® (IL-6RA), Stelara® (IL-12/23 inhibitor), Cosentyx® (IL-17A inhibitor), Taltz® (IL-17A inhibitor), Siliq™ (IL-17RA), Ilumya™ (IL-23 inhibitor), Skyrizi™ (IL-23 inhibitor), Tremfya® (IL-23 inhibitor)], Janus kinase inhibitors (JAKi) [e.g., Xeljanz®/Xeljanz® XR, Cibinqo™, Olumiant™, Rinvoq™], anti-CD20 monoclonal antibodies [Rituxan®, Riabni™, Ruxience™, Truxima®, Rituxan Hycela®], selective co-stimulation modulators [Orencia®], and integrin receptor antagonists [Entyvio®] because of the additive immunosuppression, increased risk of neutropenia, as well as increased risk of serious infections.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

AAN: American Academy of Neurology
ACR: American College of Rheumatology
AIHA: autoimmune hemolytic anemia
AHCCCS: Arizona Health Care Cost Containment System
ARR: annualized relapse rate
CDAI: clinical disease activity index
CHOP: cyclophosphamide, doxorubicin, vincristine, prednisone
CLL: chronic lymphocytic leukemia
CVP: cyclophosphamide, vincristine, prednisone
DLBCL: diffuse large B-cell lymphoma
DMARD: disease-modifying antirheumatic drug
EDSS: Expanded Disability Status Scale
FC: fludarabine and cyclophosphamide
FDA: Food and Drug Administration
FL: follicular lymphoma
GPA: granulomatosis with polyangiitis (Wegener's granulomatosis)
IMN: idiopathic membranous nephropathy
ITP: immune thrombocytopenia
JAKi: Janus kinase inhibitors
MALT: mucosa-associated lymphoid tissue
MPA: microscopic polyangiitis
MS: multiple sclerosis
MTX: methotrexate
NCCN: National Comprehensive Cancer Network
NHL: Non-Hodgkin's lymphoma
NMOSD: neuromyelitis optica spectrum disorder
NS: nephrotic syndrome
PF: pemphigus foliaceus
PPMS: primary progressive MS
PV: pemphigus vulgaris
RA: rheumatoid arthritis

RAPID3: routine assessment of patient index data 3
RCT: randomized controlled trial
RRMS: relapsing-remitting MS
SLL: small lymphocytic lymphoma

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
RA		
azathioprine (Azasan®, Imuran®)	1 mg/kg/day PO QD or divided BID	2.5 mg/kg/day
Cuprimine® (d-penicillamine)*	Initial dose: 125 or 250 mg PO QD Maintenance dose: 500 – 750 mg/day PO QD	1,500 mg/day
cyclosporine (Sandimmune®, Neoral®)	2.5 – 4 mg/kg/day PO divided BID	4 mg/kg/day
hydroxychloroquine (Plaquenil®)*	Initial dose: 400 – 600 mg/day PO QD Maintenance dose: 200 – 400 mg/day PO QD	5 mg/kg/day
leflunomide (Arava®)	100 mg PO QD for 3 days, then 20 mg PO QD	20 mg/day
methotrexate (Rheumatrex®)	7.5 mg/week PO, SC, or IM or 2.5 mg PO Q12 hr for 3 doses/week	30 mg/week
Ridaura® (auranofin)	6 mg PO QD or 3 mg PO BID	9 mg/day
sulfasalazine (Azulfidine®)	2 g/day PO in divided doses	3 gm/day
Enbrel (etanercept)	25 mg SC twice weekly or 50 mg SC once weekly	50 mg/week
Humira (adalimumab)	40 mg SC every other week (may increase to once weekly)	40 mg/week
Avsola™, Renflexis™, Inflectra® (infliximab)	In conjunction with MTX Initial dose: 3 mg/kg IV at weeks 0, 2 and 6 Maintenance dose: 3 mg/kg IV every 8 weeks Some patients may benefit from increasing the dose up to 10 mg/kg or treating as often as every 4 weeks	10 mg/kg every 4 weeks
GPA, MPA		

CLINICAL POLICY
Rituximab, Rituximab-arrx, Rituximab-pvvr, Rituximab-abbs, Rituximab-Hyaluronidase

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
glucocorticoids	Varies	Varies
ITP		
corticosteroids	Varies	Varies
immune globulins (e.g., Carimune® NF, Flebogamma® DIF 10%, Gammagard® S/D, Gammaked™, Gamunex®-C, Gammaplex®, Octagam® 10%, Privigen®)	Refer to prescribing information	Refer to prescribing information
DM		
azathioprine (Imuran®)*	2 mg/kg PO QD or 50 mg/day PO up to 2 to 3 mg/kg/day	Not applicable
cyclophosphamide (Cytoxan®)*	1 to 3 mg/kg/day PO QD or 500 mg IV every 2 weeks for 6 doses	Not applicable
cyclosporine (Gengraf®, Neoral®, Sandimmune®)*	5 to 10 mg/kg/day PO	Not applicable
methotrexate (Rheumatrex®)*	10 to 25 mg/week PO/IV	50 mg/week
mycophenolate mofetil (Cellcept®)*	250 to 500 mg PO BID, increasing to a target dose of 1,500-3,000 mg/day	3 g/day
tacrolimus (Prograf®)*	0.075 mg/kg/day PO BID OR begin at 1 mg PO BID, increase to reach trough of 5-10 ng/mL	Not applicable
Systemic corticosteroids (e.g., prednisone, prednisolone, methylprednisolone)	Varies	Varies
NS		
Systemic corticosteroids* (e.g., prednisone)	prednisone: 60 mg/m^2 PO per day or 2 mg/kg PO per day until urine protein tests are negative or trace for three consecutive days	Varies
tacrolimus (Prograf®)*	0.05-0.1 mg/kg/day PO (starting dose) given in two divided doses	Varies
cyclosporine (Neoral®, Sandimmune®)*	4-5 mg/kg/day PO in two equally divided doses 12 hours apart	5 mg/kg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
cyclophosphamide*	2 mg/kg/day PO for 12 weeks	2 mg mg/kg/day
mycophenolate (CellCept®)*	1,200 mg/m^2/day PO given in two divided doses	1,200 mg/m^2/day
Leukeran® (chlorambucil)*	0.1-0.2 mg/kg/day PO given for 8 weeks	Varies
WAIHA		
Systemic corticosteroids* (e.g., prednisone)	prednisone: 1 mg/kg/day PO for 2-3 weeks	Varies

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.
**Off-label*

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): none reported
- Boxed warning(s):
  - Fatal infusion reactions (Rituxan, Riabni, Ruxience, Truxima)
  - Severe mucocutaneous reactions, hepatitis B virus reactivation, progressive multifocal leukoencephalopathy (Rituxan, Riabni, Ruxience, Truxima, Rituxan Hycela).

Appendix D: General Information

- Definition of MTX or disease-modifying antirheumatic drug (DMARD) failure
  - Child-bearing age is not considered a contraindication for use of MTX. Each drug has risks in pregnancy. An educated patient and family planning would allow use of MTX in patients who have no intention of immediate pregnancy.
  - Social use of alcohol is not considered a contraindication for use of MTX. MTX may only be contraindicated if patients choose to drink over 14 units of alcohol per week. However, excessive alcohol drinking can lead to worsening of the condition, so patients who are serious about clinical response to therapy should refrain from excessive alcohol consumption.
- Examples of positive response to RA therapy may include, but are not limited to:
  - Reduction in joint pain/swelling/tenderness
  - Improvement in ESR/CRP levels
  - Improvements in activities of daily living
- Off-label use in multiple sclerosis (MS):
  - The off-label use of rituximab in relapsing-remitting MS (RRMS) and primary progressive MS (PPMS) is supported by Class IIb recommendations in Micromedex with the following clinical evidence:

  - RRMS: 1 randomized controlled trial (RCT) (N = 104) found there was a significant difference in T1-weighted lesion count at 24 weeks and annualized relapse rate (ARR) at 24 weeks (but not at 48 weeks) for patients receiving rituximab compared to placebo. Important limitations of this study are poor methodological quality and high risk of attrition bias resulting from a high dropout rate (40% in placebo and 15.9% in rituximab).
  - PPMS: 1 RCT (N = 439) found there was no significant difference in confirmed disability progression for patients receiving rituximab compared to placebo.
- In the 2018 MS guidelines, the American Academy of Neurology (AAN) does not prefer any one disease-modifying therapy over another for the treatment of RRMS, except for Gilenya®, Tysabri®, and Lemtrada® for highly active disease. The recommended agent in PPMS is Ocrevus®. AAN makes the following comments on rituximab:
  - RRMS:
    - Rituximab is probably more effective than placebo in decreasing the risk of relapse at 1 year.
    - There is insufficient evidence to determine the efficacy of rituximab compared with placebo in decreasing the ARR at 1 year.
    - Rituximab is probably more effective than placebo in decreasing the volume of T2 lesions from baseline to week 36.
  - PPMS: The randomized controlled trial of rituximab in PPMS was promising but inconclusive.

- Off-label use in NMOSD:
  - Rituxan is considered a standard first-line treatments for NMOSD per clinical reviews and the 2010 European Federation of Neurological Societies guideline. Comparative analyses shows that rituximab significantly reduces attack frequency and stabilizes or reduces neurological disabilities while achieving long-term safety. Neurological disability was assessed via the EDSS score, which ranges from 0 (no disability) to 10 (death).
    - In a 5-year follow-up of 30 patients from a 2-year retrospective case series, 18 (60%) were relapse free and 28 (93%) had improved or stabilized disability as evidenced by improvement in the EDSS score. The mean (SD) pretreatment versus posttreatment annualized relapse rate (ARR) was 2.4 (1.5) versus 0.3 (1.0) ($p < 0.001$). No serious adverse events resulted in discontinuation of therapy.
    - In a 1-year RCT with 68 patients who had a baseline EDSS score ≤ 7, rituximab demonstrated a higher proportion decrease in ARR (SD) than azathioprine (0.83 (0.37) compared to 0.56 (0.50), $p = 0.022$). The mean change in EDSS score (SD) was -0.98 (1.14) with rituximab versus -0.44 (0.54) with azathioprine ($p < 0.001$). There were no statistically significant difference in adverse effects.
    - A 2019 meta-analysis that included 26 studies and 577 patients showed a significant mean decrease in the ARR after rituximab therapy (-1.56 (95% CI -

1.82 to -1.29). There was no significant correlation found between AQP4-IgG serostatus and ARR or EDSS.

- Off-label use in DM:
  - Per the 2020 American Academy of Dermatology treatment guidelines for DM, rituximab is the appropriate next step in therapy in cases where a combination of systemic corticosteroids and an oral immunosuppressant fail. In individuals with vasculopathic or calcinotic lesions, adults with anti-MDA5 positivity, or children with NXP-2 positivity, rituximab plus systemic corticosteroids can be considered first-line treatment. Additionally, patients with juvenile DM and calcinosis should be preferentially treated with IVIG because it has the best data supporting its use for calcinosis specifically.
  - Failure or clinically significant adverse effects to continual high dose steroids in combination with other immunosuppressive agents is defined as the patient being unresponsive or poorly responsive to therapy (persistently elevated serum creatine kinase (CK) levels and/or lack of improvement on muscle strength improvement scales) or intolerant of therapy (i.e., steroid myopathy or severe osteoporosis).
- Off-label use in NS:
  - Idiopathic NS is defined by an association of NS with kidney biopsy findings (e.g., minimal change disease, focal segmental glomerulosclerosis, mesangial IgA, etc.) on electron microscopy and it is unclear whether these light miscropic patterns represent separate disorders or are a spectrum of a single disease.
  - Most children with idiopathic NS have MCD, which is generally responsive to steroid therapy.
- TNF blockers:
  - Etanercept (Enbrel®), adalimumab (Humira®), adalimumab-atto (Amjevita™), infliximab (Remicade®) and infliximab biosimilars (Avsola™, Renflexis™, Inflectra®), certolizumab pegol (Cimzia®), and golimumab (Simponi®, Simponi Aria®).

Appendix E: The 2010 ACR Classification Criteria for RA
Add score of categories A through D; a score of ≥ 6 out of 10 is needed for classification of a patient as having definite RA.

A	**Joint involvement**	Score
	1 large joint	0
	2-10 large joints	1
	1-3 small joints (with or without involvement of large joints)	2
	4-10 small joints (with or without involvement of large joints)	3
	> 10 joints (at least one small joint)	5
B	**Serology (at least one test result is needed for classification)**	
	Negative rheumatoid factor (RF) *and* negative anti-citrullinated protein antibody (ACPA)	0
	Low positive RF *or* low positive ACPA	2

	* *Low: < 3 x upper limit of normal*	
	High positive RF *or* high positive ACPA * *High: ≥ 3 x upper limit of normal*	3
C	**Acute phase reactants (at least one test result is needed for classification)**	
	Normal C-reactive protein (CRP) and normal erythrocyte sedimentation rate (ESR)	0
	Abnormal CRP or abnormal ESR	1
D	**Duration of symptoms**	
	< 6 weeks	0
	≥ 6 weeks	1

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose

Rituxan and rituximab biosimilars	Low-grade and follicular B-cell NHL	375 mg/m^2 IV infusion according to the following schedules:
		• Relapsed or refractory, low-grade or follicular, CD20+, B-cell NHL
		  o Once weekly for 4 or 8 doses
		  o Retreatment: once weekly for 4 doses
		• Previously untreated, follicular, CD20+, B-cell NHL:
		  o Administer on Day 1 of each cycle of chemotherapy for up to 8 doses;
		  o If complete or partial response, initiate Rituxan/Truxima maintenance treatment as a single-agent every 8 weeks for 12 doses to start 8 weeks following completion of a rituximab product in combination with chemotherapy.
		• Non-progressing, low-grade, CD20+, B-cell NHL, after first-line CVP chemotherapy:
		  o Following completion of 6-8 cycles of CVP chemotherapy, administer once weekly for 4 doses at 6-month intervals to a maximum of 16 doses.
			375 mg/m^2 IV infusion

CLINICAL POLICY
Rituximab, Rituximab-arrx, Rituximab-pvvr, Rituximab-abbs, Rituximab-Hyaluronidase

Drug Name	Indication	Dosing Regimen	Maximum Dose
Rituxan and rituximab biosimilars	Low-grade and follicular B-cell NHL	• Rituxan in combination with Zevalin for low-grade or follicular B-cell NHL: o 250 mg/m^2 IV within 4 hrs prior to administration of Indium-111-(In-111-) Zevalin and Yttrium-90-(Y-90) Zevalin. o Administer rituximab and In-111-Zevalin 7–9 days prior to rituximab and Y-90-Zevalin. o Refer to the Zevalin package insert for full prescribing information regarding the Zevalin therapeutic regimen.	375 mg/m^2 IV infusion
Rituxan	Pediatric patients ≥ 6 months with previously untreated mature B-cell NHL/ B-AL	375 mg/m^2 IV infusion, in combination with cyctemic Lymphone Malin B chemotherapy, given as 2 separate doses during each of the induction courses and one dose during each consolidation course, for a total of 6 infusions	375 mg/m^2 IV infusion

Drug Name	Indication	Dosing Regimen	Maximum Dose

Rituxan Hycela	Follicular B-cell NHL	1,400 mg rituximab and 23,400 units hyaluronidase SC according to the following schedules:
		First dose must be with IV Rituxan/Truxima if indicated with an asterisk (*).
		• Relapsed or refractory FL:
		  ○ Once weekly for 3 or 7 weeks (i.e., 4 or 8 weeks in total)*
		  ○ Retreatment: once weekly for 3 weeks (i.e., 4 weeks in total)*
		• Previously untreated FL:
		  ○ Administer on Day 1 of Cycles 2–8 of chemotherapy (every 21 days), for up to 7 cycles (i.e., up to 8 cycles in total)*
		  ○ If complete/partial response, initiate Rituxan Hycela maintenance treatment as a single-agent every 8 weeks for 12 doses to start 8 weeks following completion of Rituxan Hycela in combination with chemotherapy
		• Non-progressing FL after first-line CVP chemotherapy:
		  ○ Following completion of 6–8 cycles of CVP chemotherapy, administer once weekly for 3 weeks (i.e., 4 weeks in total) at 6 month intervals to a maximum of 16 doses*
			1,400 mg/23,400 units SC per injection

Rituxan and rituximab biosimilars	DLBCL *(a B-cell NHL)*	375 mg/m^2 IV infusion on Day 1 of each cycle of chemotherapy for up to 8 doses total.	375 mg/m^2 IV infusion
Rituxan Hycela	DLBCL *(a B-cell NHL)*	***First dose must be with IV Rituxan*** • 1,400 mg rituximab and 23,400 units hyaluronidase SC on Day 1 of Cycles 2–8 of CHOP chemotherapy for up to 7 cycles (i.e., up to 6–8 cycles in total)	1,400 mg/23,400 units SC per injection
Rituxan and rituximab biosimilars	CLL *(a B-cell NHL)*	375 mg/m^2 IV infusion on the day prior to initiation of FC chemotherapy, then 500	500 mg/m^2 per day

Drug Name	Indication	Dosing Regimen	Maximum Dose
		mg/m^2 on Day 1 of cycles 2-6 (every 28 days).	
Rituxan Hycela	CLL *(a B-cell NHL)*	***First dose must be with IV Rituxan*** • 1,600 mg/26,800 units on Day 1 of Cycles 2–6 (every 28 days) for a total of 5 cycles (i.e., 6 cycles in total)	1,600 mg/26,800 units SC per injection
Rituxan and rituximab biosimilars	RA	Two 1,000 mg IV infusions separated by 2 weeks (i.e., day 1 and day 15), followed by two 1,000 mg IV infusions every 24 weeks or based on clinical evaluation, but not sooner than every 16 weeks. Rituximab is given in combination with MTX.	Initial: 1,000 mg on day 1 and 15 Maintenance: 1,000 mg every 16 weeks
Rituxan and rituximab biosimilar	Pediatric B-cell NHL/B-AL	• 375 mg/m^2 IV infusions for a total of 6 doses in combination with Lymphome Malin B chemotherapy (2 doses in first and second induction courses and 1 dose in each consolidation course)	375 mg/m^2 for total 6 doses

Rituxan and rituximab biosimilars	GPA/ MPA	Induction:
		• 375 mg/m^2 IV once weekly for 4 weeks in combination with glucocorticoids
		Follow-up treatment if disease control with induction treatment:
		• Two 500 mg IV infusions separated by 2 weeks, followed by 500 mg IV every 6 months thereafter based on clinical evaluation. Follow up treatment should be initiated:
		  ○ Within 24 weeks after the last Rituxan induction infusion or based on clinical evaluation, but no sooner than 16 weeks after the last Rituxan induction infusion.
		  ○ Within the 4 week period following achievement of disease control if induction was achieved with other immunosuppressants.
			Induction: 375 mg/m^2 per week
			
			Follow-up treatment: 500 mg/dose (see regimen for dosing frequency)

Drug Name	Indication	Dosing Regimen	Maximum Dose
Rituxan and rituximab biosimilars	PV	Initial and maintenance therapy: • Two 1,000 mg IV infusions separated by 2 weeks with a tapering course of glucocorticoids, then 500 mg IV at month 12 and every 6 months thereafter or based on clinical evaluation Relapse: • 1,000 mg IV once. Subsequent infusions may be administered no sooner than 16 weeks following the previous infusion.	Initial/relapse: 1000 mg/dose Maintenance: 500 mg/6 months
Rituxan and rituximab biosimilars	DM*	1,000 mg/m^2 IV weekly x 2 weeks	1,000 mg/m^2 per week for total 2 doses
Rituxan and rituximab biosimilars	NS*	375 mg/m^2 IV infusion once weekly for 1 to 4 doses	375 mg/m^2/week for up to 4 doses
Rituxan and rituximab biosimilars	AIHA*	375 mg/m^2 IV infusion once weekly for 4 weeks or 1,000 mg IV infusion on days 1 and 15	375 mg/m^2/week or 1,000 mg IV infusion per week for total 2 doses

**Off-label use*

Product Availability

Drug Name	Availability
Rituximab (Rituxan)	Single-dose vials for IV injection: 100 mg/10 mL, 500 mg/50 mL
Rituximab-arrx (Riabni)	Single-dose vials for IV injection: 100 mg/10 mL, 500 mg/50 mL
Rituximab-pvvr (Ruxience)	Single-dose vials for IV injection: 100 mg/10 mL, 500 mg/50 mL
Rituximab-abbs (Truxima)	Single-dose vials for IV injection: 100 mg/10 mL, 500 mg/50 mL
Rituximab-hyaluronidase (Rituxan Hycela)	Single-dose vials for SC injection: 1,400 mg/23,400 units, 1,600 mg/26,800 units

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Coding Implications
Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	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
Q5123	Injection, rituximab-arrx, biosimilar, (Riabni), 10 mg

CLINICAL POLICY
Rituximab, Rituximab-arrx, Rituximab-pvvr, Rituximab-abbs, Rituximab-Hyaluronidase

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created to reflect AHCCCS preference of brand-name Rituxan.	04.11.20	04.20
Added criteria for off-label indication of ITP; for RA, added specific diagnostic criteria for definite RA, baseline CDAI score requirement, and decrease in CDAI score as positive response to therapy. Updated references.	07.20	07.20
For NMOSD: added requirement against concurrent use with Soliris, Enspryng, or Uplizna; modified EDSS from ≤ 7 to ≤ 8 to align with Uplizna policy.	10.21.20	10.20
Added Rituxan age expansion to pediatrics ≥ 2 years for GPA and MPA per updated FDA label; Updated HCPCS codes to include Ruxience and Truxima; Revised typo in Appendix E from "normal ESR" to "abnormal ESR" for a point gained for ACR Classification Criteria; Added criteria for RAPID3 assessment for RA given limited in-person visits during COVID-19 pandemic, updated appendices; Updated references.	02.03.21	02.21
2Q 2021 annual review: added GVHD (2A) to NCCN Compendium (off-label) section; ensured alignment of biosimilars with Rituxan throughout policy; RT4: added recently FDA-approved biosimilar Riabni to all policy criteria applicable to Rituxan; added combination of bDMARDs under Section III; updated CDAI table with ">" to prevent overlap in classification of severity; references reviewed and updated.	04.06.21	05.21
Added Care1st logo. Added verbiage to specify that criteria also applies to Care1st.	5.10.21	04.21
RT4: for Ruxience updated FDA approved indications to include RA per updated prescribing information. 2Q 2022 annual review: clarified GVHD use as steroid-refractory; added NCCN-recommended off-label use for Rosai-Dofrman disease; RT4: updated existing off-label pediatric mature B-Cell NHL criteria to reflect FDA-approved status; reiterated requirement against combination use with a bDMARD or JAKi from Section III to Sections I and II; Revised place in therapy for Xeljanz per FDA announcement and allowed bypassing Xeljanz if member had cardiovascular risk and benefits do not outweigh the risk of treatment; references reviewed and updated.	4.12.22	05.22

CLINICAL POLICY
Rituximab, Rituximab-arrx, Rituximab-pvvr, Rituximab-abbs, Rituximab-Hyaluronidase

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Effective 9/1: Riabni, Ruxience, Truxima are preferred rituximab products per AHCCCS	09.21.22	10.22
For Riabni, updated FDA approved indications to include RA per updated prescribing information; Criteria added for off-label use in DM; Expanded preferred drugs trial and failure criteria for RA from just Enbrel and Humira to 2 preferred TNF inhibitors (e.g., Avsola, Enbrel, Humira);	01.27.23	02.23
2Q 2023 annual review: criteria added for off-label use in NS; for RA, criteria updated to require a trial of three of any of the preferred Cytokine and CAM antagonists: Avsola, Enbrel, Humira, Xeljanz, Orencia instead of at least 2 preferred TNF inhibitors, Xeljanz, and Orencia; references reviewed and updated	04.05.23	05.23
Criteria added for off-label use in AIHA. References updated.	06.21.23	08.23

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a

discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.