Prescriber Criteria Form

Truxima 2026 PA Fax 4710-A v1 010126.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 (extranodal marginal zone lymphoma [EMZL] of the stomach, EMZL of nongastric sites [noncutaneous], nodal marginal zone lymphoma, splenic marginal zone lymphoma), G) Burkitt lymphoma, H) high-grade B-cell lymphoma, I) histological transformation of indolent lymphomas to diffuse large B-cell lymphoma, J) histological transformation of 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	Yes	No

	macroglobulinemia/lymphoplasmacytic lymphoma, B) Nodular lymphocyte-predominant Hodgkin lymphoma, 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 treatment response, intolerance or contraindication to methotrexate, B) the patient has had an inadequate treatment 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 yes, then no further questions.]	Yes	No
12	Does the patient have a diagnosis of neuromyelitis optica spectrum disorder? [If yes, then 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:_____