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Kaiser Foundation Health Plan of Washington Options, Inc.
CONTRACT MANAGER NAME
Provider Communications, RCB-C2W-02
PO Box 34262, Seattle WA 98124-1262

January 24, 2020

RITUXIMAB (RITUXAN®) UPDATED PRIOR AUTHORIZATION CRITERIA

Dear Provider,

Rituximab (Rituxan®) is on the non-Medicare list of office-administered drugs requiring prior authorization. **Effective April 1, 2020**, the prior authorization criteria for rituximab (Rituxan) will be revised. This letter is a notification of the upcoming change in the prior authorization criteria required before administering this medication in a physician's office.

This change applies to Kaiser Foundation Health Plan of Washington Core and SoundChoice Health Maintenance Organization (HMO) members and Kaiser Foundation Health Plan of Washington Options, Inc. Options Point Of Service (POS), Access PPO and Elect PPO Preferred Provider Organization (PPO) members. This change will **NOT** affect Medicare Advantage members.

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. requires prior authorization for a select group of injectable drugs that may be administered under the medical benefit in a physician's office or by home infusion. These reviews are intended to ensure consistent benefit adjudication as well as appropriate utilization in accordance with the Kaiser Permanente Pharmacy & Therapeutics Committee's evidence-based criteria for coverage.

Note: Pre-approval is not required for oncology diagnoses. Any oncology indication would not require patients to meet site of care criteria.

Prior Authorization Criteria (changes are in bold):

- Covered for rheumatoid arthritis patients who have clinically failed, been intolerant to, or have contraindications to methotrexate and one formulary TNF antagonist
- Covered for ITP patients who have clinically failed corticosteroid and IVIG
- Covered for treatment of granulomatosis polyangiitis (GPA or Wegener's) or microscopic polyangiitis (MPA) in patients who are antineutrophil cytoplasmic antibody (ANCA) positive
- Covered for the treatment of multiple sclerosis (MS)
- Covered for treatment of myasthenia gravis
- **Covered for patients who have had an inadequate response or intolerance to a rituximab biosimilar declared equivalent by Kaiser Permanente Pharmacy & Therapeutics Committee. Equivalent rituximab products include: rituximab-abbs (Truxima®)**

Note: Must be administered in a non-hospital setting.

Additional Information

For coverage criteria in a hospital outpatient setting and exceptions for new starts members, as well as a complete list of office-administered injectable drugs requiring prior authorization, please see

https://wa-provider.kaiserpermanente.org/static/pdf/provider/clinical-review/list-officeinject.pdf on the Kaiser Permanente provider website.

To request prior authorization review, please use the Referral Request online form located on the Kaiser Permanente provider website listed above. You can also fax your request to Review Services toll-free at 1-888-282-2685.

Thank you for the care you provide to our members, your patients. If you have any questions about this process, please call Review Services at 1-800-289-1363, Monday – Friday from 8 am to 5 pm. After business hours, please leave a voice message with your contact information. Messages received after normal business hours are returned on the next business day.

Sincerely,

Bruce Wilson, MD, Chair
Pharmacy & Therapeutics Committee