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RITUXIMAB (RITUXAN) AND RITUXIMAB-ABBS (TRUXIMA) UPDATED PRIOR AUTHORIZATION CRITERIA

Dear Provider,

Rituximab (Rituxan) and Rituximab-abbs (Truxima) are on the **non-Medicare** list of office-administered drugs requiring prior authorization. **Effective June 1, 2021,** the criteria for rituximab (Rituxan) and rituximab-abbs (Truxima) will be updated to include specific quantity limits. This letter is a notification of the upcoming change in prior authorization criteria required before administering this medication in a physician's office.

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (Kaiser Permanente) 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.

Prior Authorization Criteria for Rituximab (Rituxan) and Rituximab-abbs (Truxima) [changes are in bold]:

DRUG NAME	COVERAGE CRITERIA
RITUXIMAB	Covered for new starts who have had an inadequate response or intolerance to a rituximab biosimilar declared equivalent by Kaiser Permanente Pharmacy & Therapeutics Committee* for the following diagnoses: • Any oncology diagnoses • Rheumatoid arthritis patients who have clinically failed, been intolerant to, or have contraindications to methotrexate • ITP patients who have clinically failed corticosteroid and IVIG • Granulomatosis polyangiitis (GPA or Wegener's) or microscopic polyangiitis (MPA) in patients who are antineutrophil cytoplasmic antibody (ANCA) positive • Multiple sclerosis (MS) • Myasthenia gravis • Covered for adult patients ≥ 18 years old with thyroid eye disease (TED) who meet the following criteria: o Confirmed diagnosis of active TED by an oculoplastic surgeon o Clinical Activity Score (CAS) ≥4 (on the 7-item scale) o Moderate-to-severe active TED (not sight-threatening but has appreciable impact on daily life), associated with at least one of the following: lid retraction ≥2 mm, moderate or severe soft tissue involvement, exophthalmos ≥3 mm above normal for race and gender, or intermittent or constant diplopia o Inadequate response, intolerance, or contraindication to IV steroid therapy with or without radiation therapy

DRUG NAME	COVERAGE CRITERIA
	• Patients ≥18 years old with neuromyelitis optica spectrum disorder (NMOSD) when prescribed by or in consultation with a Multiple sclerosis specialist or Neurologist AND AQP4 antibody seropositive • Established patients on Rituxan must have a documented inadequate response or intolerance to a rituximab biosimilar OR must provide evidence that switching to a rituximab biosimilar is clinically inappropriate (documentation required). [Effective date: 2/1/2021]. * Kaiser Permanente equivalent rituximab products include rituximab-abbs (Truxima). Note: Must be administered in a non-hospital setting. See site of care prior authorization criteria for coverage criteria in a hospital outpatient setting and exceptions for new starts. Site of care restriction does NOT apply to patients less than 13 years old. Note: Any oncology indication would not require patients to meet site of care criteria. **Quantity Limits:** ○ **Rheumatoid arthritis** ▪ **Induction: 1000 mg on day 1 and 15;** ▪ **Maintenance: 1000 mg every 16 weeks** ○ **Granulomatosis polyangiitis** ▪ **Induction: 1000 mg once weekly for 4 weeks;** ▪ **Maintenance: 1000 mg every 16 weeks** ○ **Multiple Sclerosis** ▪ **Induction: 1000 mg on day 1;** ▪ **Maintenance 500 mg every 24 weeks** ○ **Note: Quantity limits do not apply to oncology diagnoses or other listed diagnoses**
RITUXIMAB-ABBS	• Criteria review not required for the following diagnoses: any oncology indication, multiple sclerosis (MS), myasthenia gravis • Rheumatoid arthritis patients who have clinically failed, been intolerant to, or have contraindications to methotrexate • 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 adult patients ≥ 18 years old with thyroid eye disease (TED) who meet the following criteria: ○ Confirmed diagnosis of active TED by an oculoplastic surgeon ○ Clinical Activity Score (CAS) ≥4 (on the 7-item scale) ○ Moderate-to-severe active TED (not sight-threatening but has appreciable impact on daily life), associated with at least one of the following: lid retraction ≥2 mm, moderate or severe soft tissue involvement, exophthalmos ≥3 mm above normal for race and gender, or intermittent or constant diplopia ○ Inadequate response, intolerance, or contraindication to IV steroid therapy with or without radiation therapy • Covered for patients ≥18 years old with neuromyelitis optica spectrum disorder (NMOSD) when prescribed by or in consultation with a Multiple sclerosis specialist or Neurologist AND AQP4 antibody seropositive

DRUG NAME	COVERAGE CRITERIA
	Note: Must be administered in a non-hospital setting. See site of care prior authorization criteria for coverage criteria in a hospital outpatient setting and exceptions for new starts. Site of care restriction does NOT apply to patients less than 13 years old. Any oncology indication would not require patients to meet site of care criteria. **Quantity Limits:** ○ **Rheumatoid arthritis** ▪ **Induction: 1000 mg on day 1 and 15;** ▪ **Maintenance: 1000 mg every 16 weeks** ○ **Granulomatosis polyangiitis** ▪ **Induction: 1000 mg once weekly for 4 weeks;** ▪ **Maintenance: 1000 mg every 16 weeks** ○ **Multiple Sclerosis** ▪ **Induction: 1000 mg on day 1;** ▪ **Maintenance 500 mg every 24 weeks** ○ **Note: Quantity limits do not apply to oncology diagnoses or other listed diagnoses**

Additional Information

A complete list of office-administered injectable drugs requiring prior authorization can be found on the Kaiser Permanente provider website at https://wa-provider.kaiserpermanente.org/ under the "Authorization & Clinical Review" section. Using the website search feature, search for the term "Non-Medicare Injectable Drugs Requiring Prior Authorization."

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 the Review Services department 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 a.m. to 5 p.m. 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,

Peter Barkett, MD, Chair
Pharmacy & Therapeutics Committee