Rituxan (rituximab)

**BENEFIT APPLICATION**

Benefit determinations are based on the applicable contract language in effect at the time the services were rendered. Exclusions, limitations or exceptions may apply. Benefits may vary based on contract, and individual member benefits must be verified. Wellmark determines medical necessity only if the benefit exists and no contract exclusions are applicable. This medical policy may not apply to FEP. Benefits are determined by the Federal Employee Program.

**DESCRIPTION**

The indications below including FDA-approved indications and compendial uses are considered covered benefits provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

**FDA-Approved Indications**

1. Non-Hodgkin’s Lymphoma (NHL) in patients with:
   a.) Relapsed or refractory, low-grade or follicular, CD20-positive, B-cell NHL as a single agent
   b.) 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
   c.) Non-progressing (including stable disease), low-grade, CD20-positive, B-cell NHL, as a single agent after first-line CVP (cyclophosphamide, vincristine, and prednisone) chemotherapy
   d.) Previously untreated diffuse large B-cell, CD20-positive NHL in combination with cyclophosphamide, doxorubicin, vincristine, and prednisone (CHOP) or other anthracycline-based chemotherapy regimens
2. Chronic Lymphocytic Leukemia (CLL), in combination with fludarabine and cyclophosphamide (FC), for the treatment of patients with previously untreated and previously treated CD20-positive CLL.
3. Granulomatosis with Polyangiitis (GPA) (Wegener’s Granulomatosis) and Microscopic Polyangiitis (MPA)
   a.) In combination with glucocorticoids
4. Moderately to severely active rheumatoid arthritis (RA)
   a) In combination with methotrexate in patients who have inadequate response to one or more TNF antagonist therapies
5. Moderate to severe pemphigus vulgaris (PV)

**Compendial Use**

1. Sjögren’s syndrome
2. Multiple sclerosis, relapsing remitting
3. Acute lymphoblastic leukemia (ALL)
4. Non-Hodgkin’s lymphoma
   a) Small lymphocytic lymphoma (SLL)
   b) Mantle cell lymphoma
   c) Marginal zone lymphomas (nodal, splenic, MALT)
d) Burkitt lymphoma
e) Primary cutaneous B-cell lymphoma
f) Castleman’s disease
g) Acquired immunodeficiency syndrome (AIDS)-related B-cell lymphoma
h) Hairy cell leukemia
i) Post-transplant lymphoproliferative disorder (PTLD)
j) Lymphoblastic lymphoma

5. Relapsed/refractory immune or idiopathic thrombocytopenic purpura (ITP)
6. Autoimmune hemolytic anemia
7. Waldenström’s macroglobulinemia/lymphoplasmacytic lymphoma (LPL)
8. Thrombotic thrombocytopenic purpura
9. Myasthenia gravis, refractory
10. Hodgkin’s lymphoma, nodular lymphocyte-predominant
11. Chronic graft-versus-host disease (GVHD)
12. Central nervous system (CNS) cancers
   a) Leptomeningeal metastases from lymphomas
   b) Primary CNS lymphoma
13. Acute lymphoblastic leukemia (ALL)
14. Prevention of Epstein-Barr virus (EBV)-related PTLD in high risk patients
15. Refractory idiopathic inflammatory myopathy
16. Neuromyelitis optica
17. Immune checkpoint inhibitor-related toxicities

17.18. Antibody-mediated rejection (AMR)

All other indications are considered experimental/investigational and are not a covered benefit.

Quantity Limits Apply

<table>
<thead>
<tr>
<th>Trade Name</th>
<th>Generic Name</th>
<th>Quantity Limit</th>
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<tbody>
<tr>
<td>Rituxan®</td>
<td>rituximab</td>
<td>200 mL (2000 mg) per 30 days</td>
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POLICY

Criteria for Initial Approval

A. Hematologic indications
   Authorization of 12 months may be granted for treatment of any of the following indications:
   1. Refractory immune or idiopathic thrombocytopenic purpura (ITP)
   2. Autoimmune hemolytic anemia
   3. Thrombotic thrombocytopenic purpura
   4. Chronic graft-versus-host disease (GVHD)
   5. Prevention of Epstein-Barr virus (EBV)-related PTLD

B. Oncologic indications
   Authorization of 12 months may be granted for treatment of any of the following oncologic disorders that are CD20-positive as confirmed by testing or analysis:
   1. Non-Hodgkin’s lymphoma (NHL) with any of the following subtypes:
      a) Diffuse large B-cell lymphoma
      b) Chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL)
      c) Follicular lymphoma
      d) Mantle cell lymphoma
      e) Marginal zone lymphomas (nodal, splenic, MALT)
f) Burkitt lymphoma  
g) Primary cutaneous B-cell lymphoma  
h) Castleman’s disease  
i) AIDS-related B-cell lymphoma  
j) Hairy cell leukemia  
k) Post-transplant lymphoproliferative disorder (PTLD)  
l) Lymphoblastic lymphoma  
2. Waldenström’s macroglobulinemia/lymphoplasmacytic lymphoma (LPL)  
3. Hodgkin’s lymphoma, nodular lymphocyte-predominant  
4. Central nervous system (CNS) cancers with either of the following:  
a) Leptomeningeal metastases from lymphomas  
b) Primary CNS lymphoma  
l) Lymphoblastic lymphoma  
5. Acute lymphoblastic leukemia (ALL)  

C. Myasthenia gravis  
Authorization of 12 months may be granted for treatment of refractory myasthenia gravis  

D. Moderately to severely active rheumatoid arthritis (RA)  
1. Authorization of 24 months may be granted to members who have previously received any  
   biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) indicated for the treatment of  
   moderately to severely active rheumatoid arthritis OR have received at least two full doses of  
   Rituxan for the treatment of RA, where the most recent dose was given within 6 months of the  
   request. Rituxan must be prescribed in combination with methotrexate (MTX) unless the  
   member has a contraindication or intolerance to MTX (see Appendix A).  
2. Authorization of 24 months may be granted for treatment of moderately to severely active RA  
   when all of the following criteria are met:  
   a) Member is prescribed Rituxan in combination with MTX or has a contraindication or  
      intolerance to MTX.  
   b) Member meets any of the following criteria:  
      i). Member has experienced an inadequate response to at least a 3-month trial of MTX  
         despite adequate dosing (i.e., titrated to 20 mg/week)  
      ii). Member has an intolerance or contraindication to MTX (see Appendix A).  

E. Moderate to severe pemphigus vulgaris (PV)  
Authorization of 24 months may be granted for treatment of PV  

F. Granulomatosis with Polyangiitis (GPA) (Wegener’s Granulomatosis) and Microscopic  
   Polyangiitis (MPA)  
Authorization of 24 months may be granted for treatment of GPA or MPA.  

G. Sjögren’s syndrome  
Authorization of 24 months may be granted for treatment of Sjögren’s syndrome.  

H. Multiple sclerosis  
Authorization of 24 months may be granted for treatment of multiple sclerosis (MS) when both of  
the following criteria are met:  
1. Member has a diagnosis of relapsing remitting MS  
2. Member has had an inadequate response to two or more disease-modifying drugs indicated  
   for MS despite adequate duration of treatment (see Appendix B)  

I. Refractory idiopathic inflammatory myopathy
Authorization of 24 months may be granted for treatment of refractory polymyositis or dermatomyositis

J. **Neuromyelitis optica**
Authorization of 24 months may be granted for treatment of neuromyelitis optica

K. **Immune checkpoint inhibitor-related toxicities**
Authorization of 3 months may be granted for treatment of immune checkpoint inhibitor-related toxicities

L. **Antibody-mediated rejection (AMR)**
Authorization of 6 months may be granted for treatment of antibody-mediated rejection following solid organ transplant

**Continuation of Therapy**

A. **Rheumatoid Arthritis**
Authorization of 24 months may be granted for all members (including new members) who meet all initial authorization criteria and achieve or maintain positive clinical response after at least two doses of therapy with Rituximab as evidenced by low disease activity or improvement in signs and symptoms of the condition.

B. **Other indications**
Authorization may be granted for all members (including new members) who meet all initial authorization criteria.

**Dosage and Administration**
Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

**Appendices**

**Appendix A: Examples of contraindications to methotrexate**
1. Alcoholism, alcoholic liver disease or other chronic liver disease
2. Breastfeeding
3. Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)
4. Elevated liver transaminases
5. History of intolerance or adverse event
6. Hypersensitivity
7. Interstitial pneumonitis or clinically significant pulmonary fibrosis
8. Myelodysplasia
9. Pregnancy or planning pregnancy (male or female)
10. Renal impairment
11. Significant drug interaction

**Appendix B: Disease-modifying drugs indicated for multiple sclerosis**
1. Aubagio (teriflunomide)
2. Avonex (interferon beta-1a)
3. Betaseron (interferon beta-1a)
4. Copaxone/Glatopa (glatiramer acetate)
5. Extavia (interferon beta-1a)
6. Gilenya (fingolimod)
7. Tecfidera (dimethyl fumarate)
8. Plegridy (peginterferon beta-1a)
9. Rebif (interferon beta-1a)
10. Tysabri (natalizumab)

**PROCEDURES AND BILLING CODES**

To report provider services, use appropriate CPT* codes, Alpha Numeric (HCPCS level 2) codes, Revenue codes, and/or ICD diagnostic codes.

- J9310 Injection, rituximab, 100 mg (cancelled 1.1.2019)
- J9312 Rituxan, Injection, rituximab, 10 mg (Effective 1.1.2019)

**REFERENCES**


**POLICY HISTORY**

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