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

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Line of Business: Commercial, HIM/ICHRA, Medicaid

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®), ritixumab-cdxx (Zimrixby™)] are CD20-directed cytolytic antibodies.

Rituximab/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.

FDA Approved Indication(s)

Indications		Rituxan	Riabni	Ruxience	Truxima	Rituxan Hycela*	Zimrixby
Oncology indications (for adults unless otherwise indicated)							
Low-grade and follicular B-cell NHL	Relapsed or refractory, low-grade *[Rituxan, Riabni, Ruxience, Truxima, Zimrixby]* or follicular *[Rituxan, Riabni, Ruxience, Truxima, Zimrixby, Rituxan Hycela]*, CD20-positive, B-cell NHL as a single agent	X	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	X
	Non-progressing (including stable disease), low-grade *[Rituxan, Riabni, Ruxience, Truxima, Zimrixby]* or follicular *[Rituxan Hycela],*	X	X	X	X	X	X

Indications		Rituxan	Riabni	Ruxience	Truxima	Rituxan Hycela*	Zimrixby
	CD20-positive B-cell NHL as a single agent after first-line CVP chemotherapy						
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	X
CLL *(a B-cell NHL)*	Previously untreated and treated CD20-positive CLL in combination with FC chemotherapy	X	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 methotrexate (MTX) in patients who have inadequate response to one or more TNF antagonist therapies	X	X	X	X		X
GPA, MPA	GPA and MPA in combination with glucocorticoids	X (2 years and older)	X (2 years and older)	X (2 years and older)	X		X
PV	Moderate to severe PV	X	X	X	X		

Abbreviations: B-AL (B-cell acute leukemia), BL (Burkitt lymphoma), BLL (Burkitt-like lymphoma), CHOP(cyclophosphamide, doxorubicin, vincristine, and prednisone), CLL (chronic lymphocytic leukemia), CVP (cyclophosphamide, vincristine, and prednisone), DLBCL (diffuse large B-cell lymphoma), FC (fludarabine and cyclophosphamide), 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.*

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 health plans affiliated with Centene Corporation® that Rituxan, Truxima, Riabni, Zimrixby, Ruxience, 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-p):
   a. B-cell acute leukemia (B-AL);
   b. Burkitt lymphoma (BL) or Burkitt-like lymphoma (BLL);
   c. Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL);
   d. Diffuse large B-cell lymphoma (DLBCL);
   e. Extranodal Marginal Zone (stomach or nongastric sites);
   f. Follicular lymphoma (FL);
   g. Hairy cell leukemia (Rituxan/Riabni/Ruxience/Truxima/Zimrixby only);
   h. High-grade B-cell lymphoma;
   i. Histologic transformation of indolent lymphomas to DLBCL;
   j. HIV-related B-cell lymphomas;
   k. MALT lymphoma (gastric or nongastric);
   l. Mantle cell lymphoma;
   m. Marginal zone lymphoma (nodal or splenic);
   n. Post-transplant lymphoproliferative disorder;
   o. Primary cutaneous B-cell lymphoma;
   p. Primary mediastinal large 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, Riabni, or Zimrixby, member meets one of the following (a, b, or c):[†]
   [†]For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
   a. If request is for Rituxan or Zimrixby, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (i and ii):
      i. Ruxience and Truxima;
      ii. If member has failed Ruxience and Truxima, then member must use Riabni;
      **Prior authorization may be required for Ruxience, Truxima, and Riabni*
   b. If request is for Riabni, member must use Ruxience and Truxima, unless clinically significant adverse effects are experienced or both are contraindicated;
      **Prior authorization may be required for Ruxience and Truxima*
   c. Request is for treatment associated cancer for a State with regulations against step therapy in certain oncology settings *(see Appendix E)*;
5. If request is for Rituxan Hycela, member has received at least one full dose of Rituxan, Riabni, Ruxience, Truxima, or Zimrixby;
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 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/Zimrixby: 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: 12 months

B. Rheumatoid Arthritis (must meet all)**:**
1. Diagnosis of RA per American College of Rheumatology (ACR) criteria (*see Appendix F*);
2. Request is for Rituxan/Riabni/Ruxience/Truxima/Zimrixby;
3. Prescribed by or in consultation with a rheumatologist;
4. Age ≥ 18 years;
5. Member meets one of the following, unless previously failed a biologic agent for RA (a or b):†

   †*For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395*
   a. Failure of a ≥ 3 consecutive month trial of MTX at up to maximally indicated doses;
   b. Member has intolerance or contraindication to MTX (*see Appendix D*), and failure of a ≥ 3 consecutive month trial of at least ONE conventional disease-modifying antirheumatic drug [DMARD] (e.g., sulfasalazine, leflunomide, hydroxychloroquine) at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated;
6. Member meets one of the following (a or b, *see Appendix B and D*):
   a. For Illinois HIM requests only: Failure of a TNF antagonist, unless contraindicated or clinically significant adverse effects are experienced;
   b. For all other requests (i or ii):
      i. Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: Avsola™, Inflectra™, Renflexis™;
      ii. History of failure of two TNF blockers;

   **Prior authorization may be required for Avsola, Inflectra and Renflexis*
7. Documentation of one of the following baseline assessment scores (a or b):
   a. Clinical disease activity index (CDAI) score (*see Appendix G*);
   b. Routine assessment of patient index data 3 (RAPID3) score (*see Appendix H*);
8. If request is for Rituxan, Riabni, or Zimrixby, member meets one of the following (a or b):†

   †*For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395*
   a. If request is for Rituxan or Zimrixby, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (i and ii):

i. Ruxience and Truxima;
ii. If member has failed Ruxience and Truxima, then member must use Riabni;
**Prior authorization may be required for Ruxience, Truxima, and Riabni*

b. If request is for Riabni, member must use Ruxience and Truxima, unless clinically significant adverse effects are experienced or both are contraindicated;
**Prior authorization may be required for Ruxience and Truxima*

9. Rituxan/Riabni/Ruxience/Truxima/Zimrixby will be administered in combination with MTX unless contraindicated or clinically significant adverse effects are experienced;
10. 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*);
11. 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: 12 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/Zimrixby;
3. Prescribed by or in consultation with a rheumatologist;
4. Member meets one of the following (a or b):
   a. For Rituxan, Riabni, Ruxience: Age ≥ 2 years;
   b. For Truxima, Zimrixby: Age ≥ 18 years;
5. If request is for Rituxan, Riabni, or Zimrixby, one of the following (a or b), unless FDA-approved age limit does not overlap:[†]
   [†]For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
   a. If request is for Rituxan or Zimrixby, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (i and ii):
      i. Ruxience and Truxima;
      ii. If member has failed Ruxience and Truxima, then member must use Riabni;
      **Prior authorization may be required for Ruxience, Truxima, and Riabni*
   b. If request is for Riabni, member must use Ruxience and Truxima, unless clinically significant adverse effects are experienced or both are contraindicated;
      **Prior authorization may be required for Ruxience and Truxima*
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. Request meets one of the following (a or b):
   a. Dose does not exceed both of the following (i and ii):
      i. Induction: 375 mg/m^2 weekly for 4 weeks;
      ii. Follow up treatment (1 or 2):

1) Adult: two 500 mg infusions separated by 2 weeks, then 500 mg every 6 months;
2) Pediatric (*Rituxan, Riabni, and Ruxience only*): two 250 mg/m^2 infusions separated by 2 weeks, then 250 mg/m^2 every 6 months;

b. If dose exceeds the FDA-approved maximum dose, dose is supported by compendium, practice guidelines, or peer-reviewed literature for the relevant off-label use (*for practice guidelines or peer-reviewed literature, prescriber must submit supporting evidence*).

Approval duration: 12 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/Zimrixby;
3. Prescribed by or in consultation with a dermatologist;
4. Age ≥ 18 years;
5. If request is for Rituxan, Riabni, or Zimrixby, member meets one of the following (a or b):[†]

   [†]*For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395*

   a. If request is for Rituxan or Zimrixby, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (i and ii):
      i. Ruxience and Truxima;
      ii. If member has failed Ruxience and Truxima, then member must use Riabni;
      **Prior authorization may be required for Ruxience, Truxima, and Riabni*
   b. If request is for Riabni, member must use Ruxience and Truxima, unless clinically significant adverse effects are experienced or both are contraindicated;
      **Prior authorization may be required for Ruxience and Truxima*
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: 12 months

E. Bullous Pemphigoid (off-label) (must meet all)**:**

1. Diagnosis of BP;
2. Request is for Rituxan/Riabni/Ruxience/Truxima/Zimrixby;
3. Prescribed by or in consultation with a dermatologist;
4. Age ≥ 18 years;
5. Inadequate response to at least one corticosteroid (e.g., prednisone) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
6. Failure of at least one non-steroidal immunosuppressive agent (e.g., azathioprine, mycophenolate mofetil, methotrexate) *(see Appendix B)* at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;

7. If request is for Rituxan, Riabni, or Zimrixby, member meets one of the following (a or b):†
   †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
   a. If request is for Rituxan or Zimrixby, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (i and ii):
      i. Ruxience and Truxima;
      ii. If member has failed Ruxience and Truxima, then member must use Riabni;
      **Prior authorization may be required for Ruxience, Truxima, and Riabni*
   b. If request is for Riabni, member must use Ruxience and Truxima, unless clinically significant adverse effects are experienced or both are contraindicated;
      **Prior authorization may be required for Ruxience and Truxima*
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. Dose does not exceed one of the following (a or b):
   a. 375 mg/m^2 (IV) weekly for 4 weeks;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 12 months

F. NCCN Compendium Indications (off-label) (must meet all)**:**
1. Diagnosis of any of the following (a-i):
   a. Acute lymphoblastic leukemia;
   b. Castleman's disease;
   c. Immune checkpoint inhibitor-related toxicities;
   d. Steroid refractory graft-versus-host disease;
   e. Leptomeningeal metastases from lymphoma;
   f. Nodular lymphocyte-predominant Hodgkin lymphoma;
   g. Primary CNS lymphoma;
   h. Rosai-Dorfman disease;
   i. Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma;
2. Request is for Rituxan/Riabni/Ruxience/Truxima/Zimrixby;
3. Prescribed by or in consultation with an oncologist or hematologist;
4. Age ≥ 18 years;
5. If request is for Rituxan, Riabni, or Zimrixby, member meets one of the following (a, b, or c):†
   †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
   a. If request is for Rituxan or Zimrixby, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (i and ii):
      i. Ruxience and Truxima;
      ii. If member has failed Ruxience and Truxima, then member must use Riabni;
      **Prior authorization may be required for Ruxience, Truxima, and Riabni*

b. If request is for Riabni, member must use Ruxience and Truxima, unless clinically significant adverse effects are experienced or both are contraindicated;
**Prior authorization may be required for Ruxience and Truxima*
c. Request is for treatment associated with cancer for a State with regulations against step therapy in certain oncology settings *(see Appendix E)*;

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: 12 months

G. 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/Zimrixby;
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. Baseline Expanded Disability Status Scale (EDSS) score ≤ 8;
7. If request is for Rituxan, Riabni, or Zimrixby, member meets one of the following (a or b):[†]
[†]*For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395*
   a. If request is for Rituxan or Zimrixby, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (i and ii):
      i. Ruxience and Truxima;
      ii. If member has failed Ruxience and Truxima, then member must use Riabni;
      **Prior authorization may be required for Ruxience, Truxima, and Riabni*
   b. If request is for Riabni, member must use Ruxience and Truxima, unless clinically significant adverse effects are experienced or both are contraindicated;
      **Prior authorization may be required for Ruxience and Truxima*
8. Rituxan/Riabni/Ruxience/Truxima/Zimrixby is not prescribed concurrently with Soliris®/Bkemv™/Epysqli®, Enspryng™, Uplizna®, or Ultomiris®;
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: 12 months

H. Immune Thrombocytopenia (off-label) (must meet all)**:**
1. Diagnosis of immune thrombocytopenia (ITP);
2. Request is for Rituxan/Riabni/Ruxience/Truxima/Zimrixby;
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, Riabni, or Zimrixby, member meets one of the following (a or b):[†]

   [†]For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
   a. If request is for Rituxan or Zimrixby, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (i and ii):
      i. Ruxience and Truxima;
      ii. If member has failed Ruxience and Truxima, then member must use Riabni;

      **Prior authorization may be required for Ruxience, Truxima, and Riabni*
   b. If request is for Riabni, member must use Ruxience and Truxima, unless clinically significant adverse effects are experienced or both are contraindicated;

      **Prior authorization may be required for Ruxience and Truxima*
7. Rituxan/Riabni/Ruxience/Truxima/Zimrixby 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

I. Dermatomyositis (off-label) (must meet all)**:**
1. Diagnosis of dermatomyositis (DM);
2. Request is for Rituxan/Riabni/Ruxience/Truxima/Zimrixby;
3. Prescribed by or in consultation 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, Riabni, or Zimrixby, member meets one of the following (a or b):[†]
   [†]For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
   a. If request is for Rituxan or Zimrixby, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (i and ii):
      i. Ruxience and Truxima;
      ii. If member has failed Ruxience and Truxima, then member must use Riabni;
      **Prior authorization may be required for Ruxience, Truxima, and Riabni*
   b. If request is for Riabni, member must use Ruxience and Truxima, unless clinically significant adverse effects are experienced or both are contraindicated;
      **Prior authorization may be required for Ruxience and Truxima*
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/m^2 IV infusion;
      ii. Followed by another 1,000 mg/m^2 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

J. 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/Zimrixby;
3. Prescribed by or in consultation 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;[†]
   [†]For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395
6. If request is for Rituxan, Riabni, or Zimrixby, member meets one of the following (a or b):[†]
   [†]For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
   a. If request is for Rituxan or Zimrixby, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (i and ii):

i. Ruxience and Truxima;
ii. If member has failed Ruxience and Truxima, then member must use Riabni;
**Prior authorization may be required for Ruxience, Truxima, and Riabni*

b. If request is for Riabni, member must use Ruxience and Truxima, unless clinically significant adverse effects are experienced or both are contraindicated;
**Prior authorization may be required for Ruxience and Truxima*

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

K. 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/Zimrixby;
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, Riabni, or Zimrixby, member meets one of the following (a or b):[†]
   [†]For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
   a. If request is for Rituxan or Zimrixby, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (i and ii):
      i. Ruxience and Truxima;
      ii. If member has failed Ruxience and Truxima, then member must use Riabni;
      **Prior authorization may be required for Ruxience, Truxima, and Riabni*
   b. If request is for Riabni, member must use Ruxience and Truxima, unless clinically significant adverse effects are experienced or both are contraindicated;
      **Prior authorization may be required for Ruxience and Truxima*
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

L. Wiskott-Aldrich Syndrome – Waskyra Pre-Treatment (off-label) (must meet all)**:**
1. Diagnosis of Wiskott-Aldrich syndrome (WAS);
2. Request is for Rituxan/Riabni/Ruxience/Truxima/Zimrixby;
3. Prescribed by or in consultation with a medical geneticist, transplant specialist, or specialist with expertise in treating WAS (e.g., hematologist, immunologist);
4. Member is scheduled to receive Waskyra™ gene therapy;
5. If request is for Rituxan, Riabni, or Zimrixby, member meets one of the following (a or b):†
   †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
   a. If request is for Rituxan or Zimrixby, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (i and ii):
      i. Ruxience and Truxima;
      ii. If member has failed Ruxience and Truxima, then member must use Riabni;
      **Prior authorization may be required for Ruxience, Truxima, and Riabni*
   b. If request is for Riabni, member must use Ruxience and Truxima, unless clinically significant adverse effects are experienced or both are contraindicated;
      **Prior authorization may be required for Ruxience and Truxima*
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 a single infusion of 375 mg/m^2;
   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

M. Other diagnoses/indications (must meet all):
1. Member meets one of the following (a or b):
   a. Request is for treatment associated with cancer for a State with regulations against step therapy in certain oncology settings *(see Appendix E*);
   b. If request is for Rituxan, Riabni, or Zimrixby, member meets one of the following (i or ii):†
      †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
      i. If request is for Rituxan or Zimrixby, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (1 and 2):
         1) Ruxience and Truxima;
         2) If member has failed Ruxience and Truxima, then member must use Riabni;
         **Prior authorization may be required for Ruxience, Truxima, and Riabni*
      ii. If request is for Riabni, member must use Ruxience and Truxima, unless clinically significant adverse effects are experienced or both are contraindicated;
      **Prior authorization may be required for Ruxience and Truxima*

2. Member meets one of the following (a, b, or c):
   a. Members with the following diagnosis may be covered if the off-label criteria policy is met: Myasthenia gravis;
   b. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (i or ii):
      i. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
      ii. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
   c. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 2b above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

II. Continued Approval

A. Immune Thrombocytopenia (off-label)**:**

1. Re-authorization is not permitted. Members must meet the initial approval criteria.

B. Approval duration: Not applicable

Wiskott-Aldrich Syndrome – Waskyra Pre-Treatment (off-label)**:**

1. Re-authorization is not permitted as rituximab and its biosimilars are indicated to be dosed one time only.

Approval duration: Not applicable

C. 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, Zimrixby, or Rituxan Hycela for a covered oncology indication and has received this medication for at least 30 days;
2. Meets one of the following (a, b, c, d, or e):
   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 RA: Member is responding positively to therapy as evidenced by one of the following (i or ii):
   i. A decrease in CDAI (*see Appendix G*) or RAPID3 (*see Appendix H*) score from baseline;
   ii. Medical justification stating inability to conduct CDAI re-assessment, and submission of RAPID3 score associated with disease severity that is similar to initial CDAI assessment or improved;
d. 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)*;
e. For all other indications: Member is responding positively to therapy;

3. If request is for Rituxan, Riabni, or Zimrixby, member meets one of the following (a, b, or c):*†
   **For GPA or MPA requests, requirements apply for members where FDA-approved age limit overlaps*
   †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
   a. Request is for treatment associated with cancer for a State with regulations against step therapy in certain oncology settings *(see Appendix E)*;
   b. If request is for Rituxan or Zimrixby, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (i and ii):
      i. Ruxience and Truxima;
      ii. If member has failed Ruxience and Truxima, then member must use Riabni;
      **Prior authorization may be required for Ruxience, Truxima, and Riabni*
   c. If request is for Riabni, member must use Ruxience and Truxima, unless clinically significant adverse effects are experienced or both are contraindicated;
      **Prior authorization may be required for Ruxience and Truxima*
4. For NMOSD: Rituxan/Riabni/Ruxience/Truxima/Zimrixby is not prescribed concurrently with Soliris/Bkemv/Epysqli, 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-ix):
      i. NHL (1 or 2):
         1) Rituxan/Riabni/Ruxience/Truxima/Zimrixby: 500 mg/m^2 per IV infusion;
         2) Rituxan Hycela: 1,600 mg/26,800 units per SC injection;
      ii. RA (Rituxan/Riabni/Ruxience/Truxima/Zimrixby): two-1,000 mg IV infusions every 16 weeks;

iii. GPA/MPA (Rituxan/Riabni/Ruxience/Truxima/Zimrixby) (1 or 2):
1) Both of the following (a and b):
a) Induction: 375 mg/m^2 IV weekly for up to 4 weeks total;
b) Follow-up treatment, one of the following (i or ii):
1) Adult: two-500 mg infusions separated by 2 weeks, then 500 mg every 6 months;
2) Pediatric (*Rituxan, Riabni, and Ruxience only*): two 250 mg/m^2 infusions separated by 2 weeks, then 250 mg/m^2 every 6 months;
2) If dose exceeds the FDA-approved maximum dose, dose is supported by compendium, practice guidelines, or peer-reviewed literature for the relevant off-label use (*for practice guidelines or peer-reviewed literature, prescriber must submit supporting evidence*);

iv. PV or PF (Rituxan/Riabni/Ruxience/Truxima/Zimrixby) (1 or 2):
1) Maintenance: 500 mg IV every 6 months (starting 12 months after initial dose);
2) Relapse: 1,000 mg IV once then 500 mg IV 16 weeks later, then 500 mg IV every 6 months;

v. BP (Rituxan/Riabni/Ruxience/Truxima/Zimrixby): 375 mg/m^2 weekly for 4 weeks;

vi. NMOSD (Rituxan/Riabni/Ruxience/Truxima/Zimrixby): 375 mg/m^2 or 1,000 mg biweekly every 6 to 12 months;

vii. DM (Rituxan/Riabni/Ruxience/Truxima/Zimrixby) (both 1 and 2):
1) Initial 1,000 mg/m^2 IV infusion;
2) Followed by another 1,000 mg/m^2 dose given two weeks after the initial dose;

viii. NS (Rituxan/Riabni/Ruxience/Truxima/Zimrixby): 375 mg/m^2 IV infusion once weekly up to 4 doses;

ix. AIHA (Rituxan/Riabni/Ruxience/Truxima/Zimrixby) (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*

Approval duration:
DM, NS, AIHA – 1 month
All other indications – 12 months

D. Other diagnoses/indications (must meet all)**:**
1. Member meets one of the following (a or b):
a. Request is for treatment associated with cancer for a State with regulations against step therapy in certain oncology settings *(see Appendix E)*;
b. If request is for Rituxan, Riabni, or Zimrixby, member meets one of the following (i or ii):[†]

[†]For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395

i. If request is for Rituxan or Zimrixby, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (1 and 2):
   1) Ruxience and Truxima;
   2) If member has failed Ruxience and Truxima, then member must use Riabni;

   **Prior authorization may be required for Ruxience, Truxima, and Riabni*

ii. If request is for Riabni, member must use Ruxience and Truxima, unless clinically significant adverse effects are experienced or both are contraindicated;

   **Prior authorization may be required for Ruxience and Truxima*

2. Member meets one of the following (a, b, or c):
   a. Members with the following diagnosis may be covered if the off-label criteria policy is met: Myasthenia gravis;
   b. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (i or ii):
      i. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
      ii. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
   c. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 2b above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for 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 – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid or evidence of coverage documents, 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® and its biosimilars, Remicade® and its biosimilars, Simponi®], interleukin agents [e.g., Actemra® (IL-6RA) and its biosimilars, Arcalyst® (IL-1 blocker), Bimzelx® (IL-17A and F antagonist), Cosentyx® (IL-17A inhibitor), Ilaris® (IL-1 blocker), Ilumya™ (IL-23 inhibitor), Kevzara® (IL-6RA), Kineret® (IL-1RA), Omvoh™ (IL-23 antagonist), Siliq™ (IL-17RA), Skyrizi™ (IL-23 inhibitor), Spevigo® (IL-36 antagonist), Stelara® (IL-12/23 inhibitor) and its biosimilars, Taltz® (IL-17A inhibitor), Tremfya® (IL-23 inhibitor)], Janus kinase inhibitors (JAKi) [e.g., Cibinqo™, Olumiant™, Rinvoq™, Xeljanz®/Xeljanz® XR,], anti-CD20 monoclonal

antibodies [Rituxan® and its biosimilars], selective co-stimulation modulators [Orencia®], integrin receptor antagonists [Entyvio®], tyrosine kinase 2 inhibitors [Sotyktu™], and sphingosine 1-phosphate receptor modulator [Velsipity™] 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
ARR: annualized relapse rate
B-AL: b-cell acute leukemia
BL: Burkitt lymphoma
BLL: Burkitt-like lymphomas
CAD: cold agglutinin disease
CDAI: clinical disease activity index
CHOP: cyclophosphamide, doxorubicin, vincristine, prednisone
CLL: chronic lymphocytic leukemia
CVP: cyclophosphamide, vincristine, prednisone
DLBCL: diffuse large B-cell lymphoma
DM: dermatomyositis
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
MCD: minimal change disease
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
WAS: Wiskott-Aldrich syndrome
WAIHA: warm autoimmune hemolytic anemia

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

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
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
Certolizumab (Cimzia®)	Initial dose: 400 mg SC at 0, 2, and 4 weeks Maintenance dose: 200 mg SC every other week (or 400 mg SC every 4 weeks)	400 mg every 4 weeks
Golimumab (Simponi®)	50 mg SC once monthly	50 mg/month
Golimumab (Simponi Aria®)	Initial dose: 2 mg/kg IV at weeks 0 and 4 Maintenance dose: 2 mg/kg IV every 8 weeks	2 mg/kg every 8 weeks
GPA, MPA		
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

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
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
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
BP		
azathioprine (Imuran®)*	1 to 3 mg/kg/day PO	3 mg/kg/day
methotrexate (Rheumatrex®)*	5 to 20 mg/week PO/IM/SC	20 mg/week
mycophenolate mofetil (Cellcept®)*	750 mg to 1 g PO BID	3 g/day
Systemic corticosteroids (e.g., prednisone)*	0.5 to 1 mg/kg/day PO	1 mg/kg/day

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, Zimrixby)
  - Severe mucocutaneous reactions, hepatitis B virus reactivation, progressive multifocal leukoencephalopathy (Rituxan, Riabni, Ruxience, Truxima, Zimrixby, 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.

- Off-label use in polyarticular juvenile idiopathic arthritis (pJIA):
  - The 2019 American College of Rheumatology/ Arthritis Foundation guideline for the Treatment of Juvenile Idiopathic Arthritis conditionally recommends rituximab as an agent for refractory disease after failing TNFi, abatacept, and tocilizumab. However, evidence level for rituximab support is of very low quality and is not favored.
    - In PICO B.10, the recommendation supports that the use of TNFi, tocilizumab, and abatacept has been established in clinical trials whereas it is lacking for rituximab. In addition, there is support that there are higher rates of serious adverse events for rituximab compared to other biologics.
    - The Voting Panel states that rituximab may be considered as an earlier alternative for RF-positive children based on data from RA, although the other 3 classes of biologics (TNFi, tocilizumab, and abatacept) would still be primarily recommended. For pediatric patients with risk factors such as RF or CPP antibodies, the guideline supports the start of a biologic but this recommendation does not specify rituximab.
- 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: States with Regulations against Redirections in Cancer

State	Step Therapy Prohibited?	Notes
FL	Yes	For stage 4 metastatic cancer and associated conditions.
GA	Yes	For stage 4 metastatic cancer. Redirection does not refer to review of medical necessity or clinical appropriateness.
IA	Yes	For standard of care stage 4 cancer drug use, supported by peer-reviewed, evidence-based literature, and approved by FDA.
IN	Yes	For advanced, metastatic cancer and associated conditions
LA	Yes≠	For stage 4 advanced, metastatic cancer or associated conditions. ≠Exception if clinically equivalent therapy, contains identical active ingredient(s), and proven to have same efficacy.
MS	Yes	For advanced metastatic cancer and associated conditions
NV	Yes	Stage 3 and stage 4 cancer patients for a prescription drug to treat the cancer or any symptom thereof of the covered person
OH	Yes	For stage 4 metastatic cancer and associated conditions
OK	Yes	For advanced metastatic cancer and associated conditions
PA	Yes	For stage 4 advanced, metastatic cancer
TN	Yes^	For cancer and associated conditions ^Exception if step therapy is for AB-rated generic equivalent, interchangeable biological product, or biosimilar product to the equivalent brand drug
TX	Yes	For stage 4 advanced, metastatic cancer and associated conditions

Appendix F: 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 * *Low: < 3 x upper limit of normal*	2
	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

Appendix G: Clinical Disease Activity Index (CDAI) Score
The CDAI is a composite index for assessing disease activity in RA. CDAI is based on the simple summation of the count of swollen/tender joint count of 28 joints along with patient and physician global assessment on VAS (0–10 cm) Scale for estimating disease activity. The CDAI score ranges from 0 to 76.

CDAI Score	Disease state interpretation
≤ 2.8	Remission
> 2.8 to ≤ 10	Low disease activity
> 10 to ≤ 22	Moderate disease activity
> 22	High disease activity

Appendix H: Routine Assessment of Patient Index Data 3 (RAPID3) Score
The RAPID3 is a pooled index of the three patient-reported ACR core data set measures: function, pain, and patient global estimate of status. Each of the individual measures is scored 0 – 10, and the maximum achievable score is 30.

RAPID3 Score	Disease state interpretation
≤ 3	Remission
3.1 to 6	Low disease activity
6.1 to 12	Moderate disease activity
> 12	High disease activity

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 rituximab 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
Rituxan and rituximab biosimilars	Low-grade and follicular B-cell NHL	• Rituximab 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

Drug Name	Indication	Dosing Regimen	Maximum Dose
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
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 rituximab if indicated with an asterisk (*).*** • Relapsed or refractory FL: o Once weekly for 3 or 7 weeks (i.e., 4 or 8 weeks in total)* o Retreatment: once weekly for 3 weeks (i.e., 4 weeks in total)* • Previously untreated FL: o 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)* o 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: o 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 rituximab*** • 1,400 mg rituximab and 23,400 units hyaluronidase SC on Day 1 of Cycles 2–8	1,400 mg/23,400

Drug Name	Indication	Dosing Regimen	Maximum Dose
		of CHOP chemotherapy for up to 7 cycles (i.e., up to 6–8 cycles in total)	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 mg/m^2 on Day 1 of cycles 2-6 (every 28 days).	500 mg/m^2 per day
Rituxan Hycela	CLL *(a B-cell NHL)*	***First dose must be with IV rituximab*** • 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:
		<u>*Adults:*</u>
		• 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 rituximab induction infusion or based on clinical evaluation, but no sooner than 16 weeks after the last rituximab 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:
			<u>*Adults:*</u>
			500 mg/dose
			
			Pediatric:
			250 mg/m^2/dose

Drug Name	Indication	Dosing Regimen	Maximum Dose
		Pediatrics: • Two 250 mg/m^2 IV infusions separated by 2 weeks, followed by 250 mg/m^2 IV every 6 months thereafter based on clinical evaluation. Follow up treatment should be initiated: o Within 24 weeks after the last rituximab induction infusion or based on clinical evaluation, but no sooner than 16 weeks after the last rituximab induction infusion. o Within the 4 week period following achievement of disease control if induction was achieved with other immunosuppressants.	
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: 1,000 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*

VI. Product Availability

Drug Name	Availability
Rituximab (Rituxan)	Single-dose vials for IV injection: 100 mg/10 mL, 500 mg/50 mL

Drug Name	Availability
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-cdxx (Zimrixby)	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

Reviews, Revisions, and Approvals	Date	P&T Approval Date
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; removed general description of "stage IV or metastatic" cancer for states with regulations against redirections; clarified other diagnoses/indications section to enforce biosimilar redirection intent; reiterated requirement against combination use with a bDMARD or JAKi from Section III to Sections I and II; references reviewed and updated.	02.21.22	05.22
RT4: for Riabni, updated FDA approved indications to include RA per updated prescribing information.	07.01.22	
Template changes applied to other diagnoses/indications and continued therapy section.	10.13.22	
Criteria added for off-label use in dermatomyositis.	11.04.22	02.23
2Q 2023 annual review: criteria added for off-label use in NS; for RA, added TNFi criteria to allow bypass if member has had history of failure of two TNF blockers; removed nephrotic syndrome in other diagnoses/indications section in initial and continued therapy; continued therapy approval duration for DM updated to 1 month; updated Appendix D with recommendations from the 2019 ACR/AR guideline for the treatment of JIA stating that rituximab is not favored as pJIA therapy; references reviewed and updated.	04.17.23	05.23
Criteria added for off-label use in AIHA; per health plan request, changed continued therapy approval duration from 12 months to 6 months for all indications excluding DM, NS, and AIHA; updated Appendix E to include Oklahoma.	05.02.23	08.23
2Q 2024 annual review: for B-Cell Lymphomas initial criteria, updated "AIDS-related B-cell lymphomas" to "HIV-related B-cell lymphomas" per NCCN compendium; for Appendix E, updated state OH description to include commercial line of business; added Bimzelx, Zymfentra, Omvoh, Sotyktu, Tofidence, Wezlana, and Velsipity to section III.B; references reviewed and updated.	01.30.24	05.24
Updated Appendix E to include Mississippi.	06.05.24	
2Q 2025 annual review: for B-cell lymphomas initial criteria, added extranodal marginal zone (stomach or nongastric sites), histologic transformation of indolent lymphomas to DLBCL, primary mediastinal large B-cell lymphoma and removed low-grade B-cell lymphoma for non-Hodgkin's lymphoma subtypes per NCCN compendium; for NCCN compendium indications, removed "in patients who are CD20 positive" for acute lymphoblastic leukemia per NCCN compendium; for NMOSD initial criteria, added Bkemv, Epysqli, and Ultomiris to list of drugs not prescribed concurrently with Rituxan/Riabni/Ruxience/Truxima; for GPA and MPA, updated	04.07.25	05.25

Reviews, Revisions, and Approvals	Date	P&T Approval Date
age to allow option for Riabni, Ruxience, Truxima: age ≥ 18 years; for continued therapy section, updated approval duration from 6 months to 12 months; updated section III.B with Spevigo and biosimilar verbiage; references reviewed and updated. Added step therapy bypass for IL HIM per IL HB 5395; for RA, revised step therapy to require a TNF antagonist for IL HIM per IL HB 5395.		
Updated Appendix E with revised language and exception for Tennessee.	05.14.25	
RT4: for Riabni, Ruxience, and Truxima, added newly approved PV indication to criteria; for GPA/MPA, added criterion "dose is supported by compendium, practice guidelines, or peer-reviewed literature for the relevant off-label use" to initial approval and continued therapy per local market request; added step therapy bypass for IL HIM per IL HB 5395.	06.24.25	
Per SDC, added off-label criteria for bullous pemphigoid; for RA, added bypass of conventional therapies if a member has failed a biologic agent to clarify intention of not stepping back from biologic agent to conventional therapy; removed Castleman Disease from B-cell lymphoma initial approval criteria as Castleman Disease is not categorized as B-cell lymphoma per NCCN and added Castleman Disease to NCCN Compendium Indications (off-label) initial approval criteria. Extended initial approval durations to 12 months for chronic conditions.	09.15.25	11.25
Added off-label criteria for WAS infection prophylaxis associated with Waskyra gene therapy.	01.14.26	02.26
2Q 2026 annual review: no significant changes; references reviewed and updated. For Appendix E, added state IN. Added ICHRA line of business.	04.03.26	05.26
RT4: added newly FDA approved biosimilar Zimrixby to criteria; updated Appendix E with revised language for Tennessee.	09.01.26	
RT4: for Ruxience and Riabni, added pediatric extension for ages 2 years and older for GPA and MPA per FDA label.	10.19.26	

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.

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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.

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