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Rituxan (rituximab)and Biosimilars

PRODUCTS AFFECTED

Rituxan (rituximab), Rituxan Hycela (rituximab and hyaluronidase human), Truxima (rituximab-abbs), Ruxience(rituximab-pvvr)

COVERAGE POLICY

Coverage for services, procedures, medical devices, and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Coverage Guideline must be read in its entirety todetermine coverage eligibility, if any.
This Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide Molina Healthcare complete medical rationale when requesting any exceptions to these guidelines

Documentation Requirements:
Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational, or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive

DIAGNOSIS:
rheumatoid arthritis, Chronic Lymphocytic Leukemia (CLL) or Small Lymphocytic Lymphoma (SLL), B-Cell Lymphoma (e.g., Follicular Lymphoma, Diffuse Large B-Cell Lymphoma [DLBCL], Acquired Immune Deficiency [AIDS]-Related B-Cell Lymphoma, Burkitt Lymphoma, Castleman's Disease, Marginal Zone Lymphoma [e.g., extranodal or MALT {gastric or nongastric}, nodal, or splenic marginal zone lymphoma], Primary Mediastinal Large B-Cell Lymphoma, Mantle Cell Lymphoma, Post-Transplant Lymphoproliferative Disorders, Gray Zone Lymphoma), Lupus nephritis (refractory),recurrent and resistant dermatomyositis and polymyositis, Autoimmune Hemolytic anemia, refractory thrombocytopenia, solid organ transplant rejection (chronic), relapsing-remitting MS, pemphigus vulgaris, systemic lupus erythematous, primary Sjogren syndrome, neuromyelitis optica

REQUIRED MEDICAL INFORMATION:
This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. If a drug within this policy receives an updated FDA label within the last 180 days, medical necessity for the member will be reviewed using the updated FDA label information along with state and federal requirements, benefit being administered and formulary preferencing. Coverage will be determined on a case-by-case basis until the criteria can be updated through Molina Healthcare, Inc. clinical governance. Additional information may be required on a case-by-case basis to allow for adequate review

IF THIS IS A NON-FORMULARY/NON-PREFERRED PRODUCT FOR INITIAL OR CONTINUATION OF THERAPY REQUEST:

1. IF THIS IS A PHARMACY BENEFIT REQUEST FOR A NON-FORMULARY/NON-PREFERRED PRODUCT: If request is for reference product with a biosimilar available for initial or continuation of therapy requests: Documentation of a trial and failure, intolerance, or contraindication to a majority (not more than 3) biosimilar product(s) is required (unless otherwise specified per applicable state regulations and/or there is data demonstrating clinical superiority of reference drugs over the FDA approved biosimilar drugs).
   [DOCUMENTATION REQUIRED-Document when the preferred biologic product or biosimilar was tried and the length of the trial period, Provide specific clinical documentation of therapeuticfailure on the preferred biologic product or biosimilar whenever possible. Describe the medical problem caused by the preferred referenced biologic. Vague and non-descriptive symptoms arenot adequate rationale (e.g., stomachache)]
   OR
2. IF THIS IS A PHYSICIAN ADMINISTERED MEDICATION REQUEST: BIOSIMILAR DRUGS are preferred when requested as a physician administered drug per applicable state regulations and/or there is a lack of data demonstrating clinical superiority of reference drugs over the FDA approved biosimilar drugs. A reference medication is approved under the following conditions:
   (a) Treatment with at least two (2) associated biosimilar drug(s) has been ineffective, not tolerated, or is contraindicated (i.e. an allergic reaction to a specific inactive ingredient in the preferred biologic product or biosimilar OR an adverse reaction to a specific inactive ingredient in the preferred biologic product or biosimilar OR therapeutic success while taking a non-preferred biologic product or biosimilar and therapeutic failure while taking the preferred biologic product or biosimilar documented by patient diary or medical charted notes)
   [DOCUMENTATION REQUIRED-Document when the preferred biologic product or biosimilar was tried and the length of the trial period, Provide specific clinical documentation of therapeutic failure on the preferred biologic product or biosimilar whenever possible. Describe the medical problem caused by the preferred referenced biologic. Vague and non-descriptive symptoms are not adequate rationale (e.g., stomachache)]

A. MODERATE TO SEVERE RHEUMATOID ARTHRITIS:

1. Documentation of moderate to severe rheumatoid arthritis diagnosis
   AND
2. Documentation of prescriber baseline disease activity evaluation and goals fortreatment to be used to evaluate efficacy of therapy at renewal
   AND
3. (a) Member is concurrently receiving methotrexate
   OR
   (b) Member tried, failed, or has an FDA labeled contraindication or intolerance to methotrexate, as determined by the prescribing physician AND Member has tried one additional disease- modifying antirheumatic drug (DMARD) (brand or generic; oral or injectable) for at least 3 months
   (NOTE: An exception to the requirement for a trial of one conventional synthetic DMARD can be made if the Member has already had a 3-month trial at least one biologic. These patients who have already tried a biologic for RA are not required to "step back" and try a conventional synthetic DMARD).
   OR
   (c) Member has early RA (defined as disease duration of < 6 months) with at least one of the following features of poor prognosis: functional limitation (e.g., based on Health Assessment

Questionnaire Disability Index [HAQ-DI] score); extra articular disease such as rheumatoid nodules, RA vasculitis, or Felty's syndrome; positive rheumatoid factor or anti-cyclic citrullinated protein (anti- CCP) antibodies; or bony erosions by radiograph
AND

4. IF THIS IS A NON-FORMULARY PRODUCT: Documentation of trial/failure of or intolerance to a majority (not more than 3) of the preferred formulary/PDL alternatives for the given diagnosis. If yes, please submit documentation including medication(s) tried, dates of trial(s) and reason for treatment failure(s).

B. ONCOLOGY INDICATIONS and POST-TRANSPLANT LYMPHOPROLIFERATIVE DISEASE:(SEE STANDARD ONCOLOGY CRITERIA)

C. PEMPHIGUS VULGARIS:

1. Documentation of a diagnosis of pemphigus vulgaris confirmed by the presence of any of the following on biopsy: Intraepithelial cleavage with acantholysis (detached keratinocytes) primarily localized to the suprabasal region, Retention of basal keratinocytes along the basement membrane zone, resulting in an appearance that resembles a "row of tombstones" or Sparse inflammatory infiltrate in the dermis with eosinophils
AND
2. Documentation of a trial (2 weeks) and inadequate response or contraindication to systemic glucocorticoids
OR
3. Rituximab is initiated in combination with a corticosteroid (e.g., prednisone),unless contraindicated
AND
4. Documentation of prescriber baseline disease activity evaluation and goals for treatment to be used to evaluate efficacy of therapy at renewal

D. CHRONIC, REFRACTORY, GRAFT-VS-HOST DISEASE

1. Documentation member has tried one immunosuppressant for graft-versus-host disease (GVHD) [e.g., one corticosteroid such as methylprednisolone, antithymocyte globulin, cyclosporine, Thalomid®{thalidomide tablets}, tacrolimus, mycophenolate mofetil, sirolimus {Rapamune®, generic}, Nipent® {pentostatin infusion}, imatinib {Gleevec®, generic}, methotrexate
OR
2. Documentation member is concurrently receiving at least one of these medications (e.g., one corticosteroid such as methylprednisolone, antithymocyte globulin, cyclosporine, Thalomid, tacrolimus, mycophenolate mofetil, sirolimus, Nipent, imatinib, or methotrexate)in combination with Rituxan.
OR
3. Documentation member was already given inpatient induction doses and request is for completion of regimen outpatient.
AND
4. Total dose is NOT over the following limit: 375 mg/m2 IV once weekly for up to four doses; OR 375 mg/m2 IV once weekly for 4 doses followed by a similar infusion once monthly or once every3 months
AND
5. Documentation of prescriber baseline disease activity evaluation and goals for treatment to be used to evaluate efficacy of therapy at renewal

E. WEGENER'S GRANULOMATOSIS (Granulomatosis with polyangiitis and microscopic polyangitis):

1. Diagnosis of Wegener's granulomatosis or microscopic polyangiitis
AND
2. Documentation that member is receiving concurrent therapy with glucocorticoids or has a history of a contraindication or intolerance to glucocorticoids
AND

3. Documentation of prescriber baseline disease activity evaluation and goals for treatment to be used to evaluate efficacy of therapy at renewal

F. PRIMARY SJORGENSYNDROME:
1. Diagnosis of moderate to severe Sjogren's syndrome
AND
2. Documentation member has tried and failed or has a contraindication to TWO of the following: hydroxychloroquine, methotrexate, azathioprine, leflunomide, mycophenolate or cyclosporine

G. NEUROMYELITIS OPTICA:
1. Diagnosis of neuromyelitis optica spectrum disorder (NMOSD)
AND
2. Documentation of Serologic testing for anti-aquaporin-4 immunoglobulin G (AQP4-IgG)/NMO-IgG antibodies
AND
3. Documentation of prescriber baseline disease activity evaluation and goals for treatment to be used to evaluate efficacy of therapy at renewal

H. RELAPSING-REMITTING MUTLIPLE SCLEROSIS:
1. Documentation of a definitive diagnosis of a relapsing form of multiple sclerosis
AND
2. Documentation that member has had an inadequate response or was unable to tolerate at least ONE other high efficacy disease-modifying agent for MS (e.g., Ocrevus™ [ocrelizumab IV infusion], Gilenya [fingolimod capsules], [Tecfidera [dimethyl fumarate delayed-release capsules], or Lemtrada [alemtuzumab IV injection])
AND
3. Rituxan IV is prescribed by or in consultation with a physician who specializes in the treatment of MS and/or a neurologist.
AND
4. Total daily dose is NOT over the following limit: 500 mg or 1,000 mg IV single infusion every 6 to12 months; Max 2000mg every 6 to 12 months
AND
5. Documentation of prescriber baseline disease activity evaluation and goals for treatment to be used to evaluate efficacy of therapy at renewal

I. REFRACTORY IDIOPATHIC THROMBOCYTOPENIA PURPURA:
1. Rituxan is prescribed by or in consultation with a hematologist
AND
2. Documentation member has tried one other therapy (e.g., intravenous immunoglobulin [IVIG], anti-D [RHO]immunoglobulin, corticosteroids, or splenectomy).
AND
3. Total dose is NOT over the following limit: 375 mg/m2 once weekly for 4 doses
AND
4. Documentation of prescriber baseline disease activity evaluation and goals for treatment to be used to evaluate efficacy of therapy at renewal

J. SYSTEMIC LUPUS ERYTHEMATOUS (SLE) AND LUPUS NEPHRITIS:
1. (a) Documentation member has neuropsychiatric manifestations of SLE AND has tried at least ONE other therapy (e.g., at least one antidepressant, antipsychotic, corticosteroid, immunosuppressant, or plasma exchange)
OR
(b) Documentation member has lupus nephritis AND has tried and failed or a labeled contraindication to BOTH immunosuppressant mycophenolate mofetil AND cyclophosphamide

with or without glucocorticoids
AND
2. Documentation of prescriber baseline disease activity evaluation and goals for treatment to be used to evaluate efficacy of therapy at renewal

K. DERMATOMYOSITIS AND POLYMYOSITIS:
1. Diagnosis of dermatomyositis or polymyositis confirmed by positive biopsy
AND
2. A baseline physical examination required. Submit documentation.
NOTE: Requests for continuation of therapy must demonstrate measurable, objective response within 3 months of initiation (i.e., improvement in CPK levels, increase or stabilization of muscle strength, or EMG abnormalities)
AND
3. Documentation of ALL of the following: (i) Severe active disease state AND (ii) Muscle weakness in all upper and/or lower limbs
AND
4. Documented refractory* disease that has failed to respond to at least an adequate three(3)month trial of the following first and second-line conventional therapies (unless contraindicated):
(a) Corticosteroids AND Immunosuppressants (e.g., azathioprine, methotrexate, cyclophosphamide, and cyclosporine)
OR
(b) Documentation of profound, rapidly progressive and/or potentially life-threatening muscular weakness refractory to prior therapy

**Refractory disease is evidenced by persistently elevated serum creatine kinase and/or lack of improvement on muscle strength improvement scales*

L. AUTOIMMUNE HEMOLYTIC ANEMIA:
1. Diagnosis of warm-type autoimmune hemolytic anemia confirmed by detection of antibody and/or complement components on the surface of the RBC [usually by the direct antiglobulin (Coombs) test]
AND
2. Documentation member is refractory to, is intolerant of, or contraindicated to ALL available alternative treatments: corticosteroid therapy, immunosuppressive agents, plasmapheresis, and Member has had a splenectomy or is the Member at high risk for post-splenectomy sepsis

CONTINUATION OF THERAPY:

A. ALL INDICATIONS:
1. For all chronic disease treatment regimens- adherence to therapy at least 85% of the time as verified by the prescriber or member medication fill history OR adherence less than 85% of the time due to the need for surgery or treatment of an infection, causing temporary discontinuation (documentation required)
AND
2. Documentation of no intolerable adverse effects or drug toxicity
AND
3. Documentation of positive clinical response as demonstrated by low disease activity and/or improvements in the condition's signs and symptoms.
AND
4. IF THIS IS A PHARMACY BENEFIT REQUEST FOR A REFERENCE PRODUCT WITH A BIOSIMILAR AVAILABLE: Documentation of a trial and failure, intolerance, or contraindication to a majority (not more than 3) biosimilar product(s) is required (unless otherwise specified per applicable state regulations and/or there is data demonstrating clinical superiority of reference drugs over the FDA approved biosimilar drugs).
[DOCUMENTATION REQUIRED-Document when the preferred biologic product or biosimilar was

tried and the length of the trial period, Provide specific clinical documentation of therapeutic failure on the preferred biologic product or biosimilar whenever possible. Describe the medical problem caused by the preferred referenced biologic. Vague and non-descriptive symptoms are not adequate rationale (e.g., stomachache)]
OR

5. IF THIS IS A PHYSICIAN ADMINISTERED MEDICATION REQUEST: BIOSIMILAR DRUGS are preferred when requested as a physician administered drug per applicable state regulations and/or there is a lack of data demonstrating clinical superiority of reference drugs over the FDA approved biosimilar drugs. A reference medication is approved under the following conditions:
(a) Treatment with at least two (2) associated biosimilar drug(s) has been ineffective, not tolerated, or is contraindicated (i.e. an allergic reaction to a specific inactive ingredient in the preferred biologic product or biosimilar OR an adverse reaction to a specific inactive ingredient in the preferred biologic product or biosimilar OR therapeutic success while taking a non-preferred biologic product or biosimilar and therapeutic failure while taking the preferred biologic product or biosimilar documented by patient diary or medical charted notes)
[DOCUMENTATION REQUIRED-Document when the preferred biologic product or biosimilar was tried and the length of the trial period, Provide specific clinical documentation of therapeutic failure on the preferred biologic product or biosimilar whenever possible. Describe the medical problem caused by the preferred referenced biologic. Vague and non-descriptive symptoms are not adequate rationale (e.g., stomachache)]

DURATION OF APPROVAL:
MODERATE TO SEVERE RHEUMATOID ARTHRITIS, NEUROMYELITIS OPTICA, WEGENER'S GRANULOMATOSIS (Granulomatosis with polyangiitis and microscopic polyangitis): 6 months initial, Continuation of therapy 12 months

PRIMARY SJOGREN'S SYNDROME: 1-month, single course of two doses

PEMPHIGUS VULGARIS, GRAFT VERSUS HOST DISEASE (CHRONIC, REFRACTORY): Initial authorization: 1 month, Continuation of therapy: 6 months

REFRACTORY THROMBOCYTOPENIA: Initial authorization: 1 month, Continuation of therapy: additional 1 month if 6 months or greater have passed since the first dose of previous Rituxan regimen *NOTE: Any requests outside of this duration please refer to off-label policy*

RELAPSE-REMITTING MUTLIPLE SCLEROSIS AND SLE/LUPUS NEPHRITIS: Initial authorization: 6 months Continuation of therapy: 12 months

DERMATOMYOSITIS AND POLYMYOSITIS: Initial: May authorize up to 3 months Continuation of therapy: May authorize up to 6 months

AUTOIMMUNE HEMOLYTIC ANEMIA: May authorize up to 6 months (initial and continuation)

PRESCRIBER REQUIREMENTS:
Prescribed by or in consultation with a specialist in the area of disease being treated. Consultation notes must be provided a minimum of annually.

AGE RESTRICTIONS:
≥ 2 years for Wegener's granulomatosis indication only
18 years of age or older for other indications

QUANTITY:
MODERATE TO SEVERE RHEUMATOID ARTHRITIS: Two 500 or 1,000 mg IV infusions

separated by 2 weeks on days 1 and 15 (in combination with methotrexate); subsequent courses maybe administered every 24 weeks (based on clinical evaluation), if necessary, may be repeated no sooner than every 16 weeks.

PEMPHIGUS VULGARIS: Two 1,000 mg IV infusions separated by 2 weeks given as initial therapy or treatment of relapse; AND Subsequent 500 mg maintenance doses are given every 6 months (minimum of 16 weeks between doses) beginning 12 months following the initial dose

SOLID CHRONIC, REFRACTORY, GRAFT-VS-HOST DISEASE:
375 mg/m2 IV once weekly for up to four doses; OR 375 mg/m2 IV once weekly for 4 doses followed by a similar infusion once monthly or once every 3 months

REFRACTORY THROMBOCYTOPENIA: 375 mg/m2 IV once weekly for 4 doses

RELAPSE- REMITTING MULTIPLE SCLEROSIS: Initial dose of 500 mg to 2,000 mg (may be divided into two infusions within 1 month). Repeat doses of 500 mg to 2,000 mg IV (may be divided into two infusions within 1 month) if at least 6 months has elapsed since the previous dose.

SLE/LUPUS NEPHRITIS: IV: 375 mg/m2 once weekly for 4 doses or 1,000 mg (flat dose) on days 0and 15 or 500 to 1,000 mg (flat dose) on days 1 and 15

DERMATOMYOSITIS AND POLYMYOSITIS: Initial dose: 2,000 mg per month, Maintenance dose:500 – 1,000 mg per month

AUTOIMMUNE HEMOLYTIC ANEMIA: 375 mg/m2 weekly for 4 doses

WEGENER'S GRANULOMATOSIS (Granulomatosis with polyangiitis and microscopic polyangitis):
For adult members (≥ 18 years): Induction therapy (for active granulomatosis with polyangiitis): 375mg/m2once weekly for 4doses. Follow- up therapy (after achieving disease control with induction): 500 mg as two infusions separated by 2 weeks, followed by 500 mg once every 6 months thereafter
For Pediatric members (≥2- 17 years): Induction dosing: 375 mg/m^2 weekly for 4 doses. Follow- up therapy (after achieving disease control with induction): 250 mg/m^2 as two infusions separated by 2 weeks, followed by 250 mg/m^2 once every 6 months thereafter.

PRIMARY SJORGEN SYNDROME: 1000 mg IV infusion on days 1 and 15

NEUROMYELITIS OPTICA: 1000 mg once every 2 weeks for 2 doses, repeat every 6 months or when monthlyCD19 cells counts are >0.1% of total lymphocytes

PLACE OF ADMINISTRATION:
The recommendation is that injectable medications in this policy will be for pharmacy or medical benefit coverage and the subcutaneous injectable products administered in a place of service that is a non-hospital facility-based location.

The recommendation is that infused medications in this policy will be for pharmacy or medical benefit coverage administered in a place of service that is a non-hospital facility-based location as per the Molina Health Care Site of Care program.

Note: Site of Care Utilization Management Policy applies for Rituxan (rituximab), Ruxience (rituximab-pvvr) and Truxima (rituximab-abbs). For information on site of care, see

Specialty Medication Administration Site of Care Coverage Criteria (molinamarketplace.com)

DRUG INFORMATION

ROUTE OF ADMINISTRATION:
Intravenous, Subcutaneous

DRUG CLASS:
Antineoplastic

FDA-APPROVED USES:
Rituxan (rituximab) is indicated for the following uses: in combination with methotrexate (MTX), for the treatment of adult patients with moderately to severely active RA who have had an inadequate response to one or more tumor necrosis factor (TNF) antagonist therapies; AND treatment of relapsed or refractory, low-grade or follicular, CD20-positive, B-cell, NHL1; AND for 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 a single- agent maintenance therapy; AND treatment of non-progressing (including stable disease)
low-grade, CD20-positive, B-cell NHL as a single agent after first-line cyclophosphamide/vincristine/prednisone (CVP) chemotherapy; AND treatment of previously untreated diffuse large B-cell, CD20-positive NHL in combination with cyclophosphamide/doxorubicin/vincristine/prednisone (CHOP) or other anthracycline-based chemotherapy regimens; AND in combination with fludarabine and cyclophosphamide (FC) for the

treatment of patients with previously untreated and previously treated CD20-positive chronic lymphocytic leukemia (CLL); AND treatment of adults with Wegener's Granulomatosis (granulomatosis with polyangitis) and Microscopic polyarteritis nodosa in combination with glucocorticoids AND Pemphigus vulgaris (Moderate to Severe) AND Microscopic polyangiitis (MPA)

Rituxan Hycela (rituximab and hyaluronidase human) is indicated for: Relapsed or refractory, follicular lymphoma as a single agent or previously untreated follicular lymphoma in combination with first line chemotherapy and, in patients achieving a complete or partial response to rituximab in combination with chemotherapy, as single agent maintenance therapy or non-progressing (including stable disease), follicular lymphoma as a single agent after first-line cyclophosphamide, vincristine, and prednisone (CVP) chemotherapy AND Previously untreated diffuse large B-cell lymphoma in combination with cyclophosphamide, doxorubicin, vincristine, prednisone (CHOP) or other anthracycline-based chemotherapy regimens AND Previously untreated and previously treated CLL in combination with fludarabine and cyclophosphamide (FC)

RUXIENCE (rituximab-pvvr) is indicated for the treatment of adult members with: 1. Non-Hodgkin's Lymphoma (NHL) which is i. Relapsed or refractory, low grade, or follicular, CD20-positive B-cell NHL as asingle agent; ii. previously untreated follicular, CD20-positive, B-cell NHL in combination with first line chemotherapy and, in members achieving a complete or partial response to a rituximab product in combination with chemotherapy, as single-agent maintenance therapy; ii. Non-progressing (including stable disease), low-grade, CD20-positive, B-cell NHL as a single agent after first-line cyclophosphamide, vincristine, and prednisone (CVP) chemotherapy; iii. Previously untreated diffuse large B-cell, CD20-positive NHL in combination with (cyclophosphamide, doxorubicin, vincristine, and prednisone) (CHOP) orother anthracycline-based chemotherapy regimens; 2. Chronic Lymphocytic Leukemia (CLL) previously untreated and previously treated CD20-positive CLL in combination with fludarabine and cyclophosphamide (FC); AND 3. Granulomatosis with Polyangiitis (GPA) (Wegener's Granulomatosis) and Microscopic Polyangiitis (MPA) in combination with glucocorticoids.

TRUXIMA (rituximab-abbs) is indicated for the treatment of adult members with: 1. Non-Hodgkin's Lymphoma (NHL) which is i. Relapsed or refractory, low grade or follicular, CD20-positive B-cell NHL as a single agent; ii. previously untreated follicular, CD20-positive, B-cell NHL in combination with first line chemotherapy and, in members achieving a complete or partial response to a rituximab product in combination with chemotherapy, as single-agent maintenance therapy; ii. Non-progressing (including stable disease), low-grade, CD20-positive, B-cell NHL as a single agent after first-line cyclophosphamide, vincristine, and prednisone (CVP) chemotherapy; iii. Previously untreated diffuse large B-cell, CD20-positive NHL in combination with (cyclophosphamide, doxorubicin, vincristine, and prednisone) (CHOP) orother anthracycline-based chemotherapy regimens; 2. Chronic Lymphocytic Leukemia (CLL) previously untreated and previously treated CD20-positive CLL in combination with fludarabine and cyclophosphamide (FC); AND 3. Granulomatosis with Polyangiitis (GPA) (Wegener's Granulomatosis) and Microscopic Polyangiitis (MPA) in combination with glucocorticoids; 4. Rheumatoid Arthritis (RA) in combination with methotrexate in adult members with moderately-to severely-active RA who have inadequate response to one or more
TNF antagonist therapies

COMPENDIAL APPROVED OFF-LABELED USES:
Lupus nephritis (refractory), recurrent and resistant dermatomyositis and polymyositis, Autoimmune Hemolytic anemia, refractory thrombocytopenia, solid organ transplant rejection (chronic), relapsing-remitting MS, pemphigus vulgaris, systemic lupus erythematous, primary Sjogren syndrome, neuromyelitis Optica

APPENDIX

APPENDIX:
A biosimilar is highly similar version of a brand name biological drug that meets strict controls for structural, pharmaceutical, and clinical consistency. A biosimilar manufacturer must demonstrate that there are no meaningful clinical differences (i.e., safety and efficacy) between the biosimilar and the reference product. Clinical performance is demonstrated through human pharmacokinetic (exposure) and pharmacodynamic (response) studies, an assessment of clinical immunogenicity, and, if needed, additional clinical studies.1 As costs for biological specialty drugs continue to rise, the growing biosimilar market will benefit providers and patients by broadening biological treatment options and expanding access to these medications at lower costs. Molina Healthcare, Inc. continues to be committed to continually reevaluating Preferred strategies and applying innovative cost-controls to ensure patients receive safe, effective, and quality healthcare. This commitment includes potentially creating a preference for biosimilars when value can be added without compromising Member satisfaction and safety.
1. Food and Drug Administration. Biosimilar and Interchangeable Products. Retrieved from https://www.fda.gov/drugs/biosimilars/biosimilar- and-interchangeable-products.AccessedOctober8, 2019.
The use of Rituxan is also supported in clinical guidelines in numerous other situations, both as first-line therapy and in patients who are refractory or have relapsed following treatment with other therapies.2-8Rituxan features prominently in the National Comprehensive Cancer Network (NCCN) guidelines for treatment of B-cell lymphomas and CLL/small lymphocytic lymphoma and is included in multiple treatment regimens across the spectrum of disease.
Guidelines from the American College of Rheumatology (ACR) [2015] have tumor inhibitors andnon-TNF biologics (including Rituxan IV), equally positioned following a trial of a conventional synthetic DMARD. EULAR/ERA-EDTA recommendations for ANCA-associated vasculitis mention Rituxan in combination with low-dose corticosteroids as a potential treatment option for remission-maintenance therapy. Remission-maintenance therapy is recommended for at least 24 months following induction of sustained remission. The British Committee for Standards in Hematology (BCSH) and the British Society for Bone Marrow Transplant recommendations for the management of chronic GVHD (2012) list Rituxan as a potential second-line treatment for patients with refractory cutaneous or musculoskeletal chronic GVHD or third-line

for treatment of GVHD involving other organs.
Guidelines from the American Society of Hematology (ASH) for ITP (2011) mention Rituxan as an appropriate agent for children and adolescents with ITP who have significant on-going bleeding despite treatment with intravenous immunoglobulin G (IVIG), anti-D, or corticosteroids.3 Rituxan is also appropriate as an alternative to splenectomy in children/adolescents with chronic ITP or in Member who do not respond to splenectomy. In adults, Rituxan in recommended for patients with ITP who are at risk for bleeding and who have failed one other line of therapy (e.g., corticosteroids, IVIg, splenectomy).
EULAR recommendations for the management of systemic lupus erythematosus with neuropsychiatric manifestations (2010) mention Rituxan as a therapeutic option for patients with neuropsychiatric SLE refractory to standard immunosuppressive therapies.4 Rituxan is used in patients with a refractory acute confusional state or other psychiatric disorders (e.g., lupus psychosis), and in severe peripheral nervous system disorders (e.g., polyneuropathy, mononeuropathy, acute inflammatory demyelinating polyradiculoneuropathy, myasthenia gravis, plexopathy). EULAR in combination with the European Renal Association-European Dialysis and Transplant Association (ERA-EDTA) has recommendations for the management of adult and pediatric lupus nephritis (2012).19 Rituxan is an alternative for patients who do not respond to first-line therapies. ACR recommendations for management of lupus nephritis (2012)5 note that Rituxan may be appropriate in certain patients with lupus nephritis who have tried mycophenolate mofetil and cyclophosphamide and in patients whose nephritis fails to improve or worsens following 6 months of one induction therapy

BACKGROUND AND OTHER CONSIDERATIONS

BACKGROUND:
Rituxan Hycela is a combination of rituximab and hyaluronidase human. It contains the identical molecular antibody of rituximab available in Rituxan IV, but hyaluronidase has been added to facilitate systemic delivery. Rituxan Hycela should be administered under the care of a healthcare professional with appropriate medical support to manage severe and potentially fatal reactions. The dose of Rituxan Hycela is fixed regardless of the patient's body surface area (BSA); dose reductions are not recommended. When given in combination with chemotherapy, reduce the dose of chemotherapeutic drugs to manage adverse events (AEs). Rituxan Hycela is not indicated for treatment of non-malignant conditions

CONTRAINDICATIONS/EXCLUSIONS/DISCONTINUATION:
All other uses of Rituxan (rituximab), Truxima (rituximab-abbs), Ruxience (rituximab-pvvr), and Rituxan Hycela(rituximab and hyaluronidase human) are considered experimental/investigational and therefore, will follow Molina's Off-Label policy

OTHER SPECIAL CONSIDERATIONS:
Waste Management for All Indications. Dosing is either a standard dose (e.g., 1,000 mg/dose) or the dose is based on body surface area (kg/m2). • If a standard dose is used, use the lowest amount of Rituxan possible to achieve the dose required. • If the dose is based on body surface area, the dose should be calculated, and the number of vials needed assessed.

Rituxan Hycela has not been shown to be effective, or there are limited or preliminary data or potential safety concerns that are not supportive of general approval for the following conditions: Granulomatosis with Polyangiitis (GPA) [Wegener's granulomatosis] or Microscopic Polyangiitis (MPA): Rituxan IV is indicated for treatment of GPA or MPA. Rituxan Hycela has not been evaluated and does not have established dosing for GPA or MPA. Rheumatoid Arthritis (RA): Rituxan IV is indicated for treatment of RA.5 Rituxan Hycela has not been evaluated and does not

have established dosing for RA.

CODING/BILLING INFORMATION

Note: 1) This list of codes may not be all-inclusive. 2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement

HCPCS CODE	DESCRIPTION
J9312	Injection, rituximab (Rituxan), 10mg
J9311	Injection, rituximab 10mgand hyaluronidsase (Rituxan Hycela)
Q5115	Truxima (rituximab-abbs)
Q5119	Ruxience (rituximab- pvvr)

AVAILABLE DOSAGE FORMS:
Rituxan solution 100mg/10ml
Rituxan solution 500mg/50ml
Rituxan Hycela solution 1400-23400mg-ut/11.7ml
Rituxan Hycela solution 1400-26800 mg-ut/13.4ml
Truxima (rituximab-abbs)100 mg/10 mL
Truxima 500 mg/50 mL
Ruxience (rituximab-pvvr) 100 mg/10 mL, 500 mg/50 mL

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