Custom Criteria for
BlueCross Blue Shield of Rhode Island Commercial

RITUXAN® (rituximab)

GPI CODING:

21353060001310

DESCRIPTION:

Rituxan, in combination with methotrexate, is FDA approved for the treatment of rheumatoid arthritis (RA) in adult patients with moderately-to-severely active RA who have inadequate response to one or more tumor necrosis factor antagonist therapies. Rituxan is also approved for the treatment of non-Hodgkin's lymphoma, chronic lymphocytic leukemia (CLL), Wegener's granulomatosis, and microscopic polyangiitis.

APPROVAL DURATION:

Rheumatoid arthritis: lifetime
Other indications: 1 year (unless state regulations require otherwise)

CRITERIA FOR RITUXAN

I. Diagnosis is rheumatoid arthritis (adult) – patient must meet all of the following:
   A. Patient is 18 years of age or older
   B. Patient has a diagnosis of moderately to severely active rheumatoid arthritis
   C. Patient is currently taking methotrexate OR has a documented contraindication or another clinical reason for not taking methotrexate
      i. Current pregnancy or planning pregnancy
      ii. Breastfeeding
      iii. Pre-existing blood dyscrasia (eg, leukopenia, thrombocytopenia, significant anemia, bone marrow hypoplasia)
      iv. History of myelodysplasia
      v. Lymphoproliferative disease diagnosed and/or treated within last 5 years
      vi. Alcoholism, alcoholic liver disease or other chronic liver disease
      vii. Hepatitis C or hepatitis B
      viii. Abnormal liver transaminases
      ix. Renal impairment
      x. Pneumonitis or interstitial lung disease
      xi. Known hypersensitivity to MTX
      xii. History of allergic reaction or adverse event
      xiii. Inability to tolerate medication/unpleasant side effect
      xiv. Significant drug interaction
   D. Patient has had an inadequate response to at least 2 tumor necrosis factor antagonists, or such therapy is contraindicated or not tolerated:
      i. Cimzia (certolizumab pegol)
      ii. Enbrel (etanercept)
      iii. Humira (adalimumab)
      iv. Remicade (infliximab)
      v. Simponi (golimumab)

II. Diagnosis is CD20-positive, B-cell non-Hodgkin's lymphoma **OR**
III. Diagnosis is CD20-positive chronic lymphocytic leukemia **OR**
IV. Diagnosis is Wegener's granulomatosis or microscopic polyangiitis **OR**
V. Diagnosis is one of the following non-oncology, medically accepted off-label uses:
    A. Relapsed/refractory Waldenstrom's macroglobulinemia
    B. Immune or idiopathic thrombocytopenic purpura