Corporate Medical Policy: Rituximab (Rituxan®) and Rituximab Biosimilars for the Treatment of Non-Oncologic Indications **"Notification"**
POLICY EFFECTIVE JULY 1, 2026

Restricted Product(s):

- *rituximab (Rituxan®) intravenous infusion for administration by a healthcare professional
- ***rituximab-arrx (Riabni®) intravenous infusion for administration by a healthcare professional
- ***rituximab-pvvr (Ruxience®) intravenous infusion for administration by a healthcare professional
- ***rituximab-abbs (Truxima®) intravenous infusion for administration by a healthcare professional
- *Any other approved rituximab biosimilars

***preferred agent(s)**
***non-preferred agent(s)**

FDA Approved Use:

- For the treatment of moderately to severely active rheumatoid arthritis (RA) in combination with methotrexate in adults who have had an inadequate response to one or more TNF antagonist therapies
- For the treatment of granulomatosis with polyangiitis (GPA) (Wegener's granulomatosis) and microscopic polyangiitis (MPA) in combination with glucocorticoids in adult and pediatric patients 2 years of age and older
- For the treatment of moderate to severe pemphigus vulgaris (PV) in adults

Criteria for Medical Necessity:

The restricted product(s) may be considered medically necessary for covered when the following criteria are met:

1. If the request is for rituximab (Rituxan) or a non-preferred rituximab biosimilar product, ONE of the following:
    a. The patient has tried and had an inadequate response to ALL of the following preferred rituximab biosimilar products: rituximab-arrx (Riabni), rituximab-pvvr (Ruxience), AND rituximab-abbs (Truxima) **[medical record documentation required]**; **OR**
    b. The patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ALL preferred rituximab biosimilar products (i.e., rituximab-arrx [Riabni], rituximab-pvvr [Ruxience], AND rituximab-abbs [Truxima]) that is NOT expected to occur with the requested product **[medical record documentation required]**; **OR**

c. The patient has a documented serious adverse event that required medical intervention to ALL preferred rituximab biosimilar products (i.e., rituximab-arrx [Riabni], rituximab-pvvr [Ruxience], AND rituximab-abbs [Truxima]) that is NOT anticipated with the requested product **[medical record documentation required]**; **AND**
    i. The prescriber has completed and submitted an FDA MedWatch Adverse Event Reporting Form **[medical record documentation required]**; **AND**

2. ONE of the following:
    a. The patient has a diagnosis of moderately to severely active **rheumatoid arthritis (RA)**; **AND**
        i. The patient is 18 years of age or older; **AND**
        ii. ONE of the following:
            1. The patient has tried and had an inadequate response to maximally tolerated methotrexate (e.g., titrated to 25 mg weekly) for at least 3-months **[medical record documentation required]**; **OR**
            2. The patient has tried and had an inadequate response to another conventional agent (i.e., hydroxychloroquine, leflunomide, sulfasalazine) used in the treatment of RA for at least 3-months **[medical record documentation required]**; **OR**
            3. The patient has an intolerance or hypersensitivity to ONE of the following conventional agents (i.e., maximally tolerated methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) used in the treatment of RA **[medical record documentation required]**; **OR**
            4. The patient has an FDA labeled contraindication to ALL of the following conventional agents (i.e., methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) used in the treatment of RA **[medical record documentation required]**; **AND**
        iii. ONE of the following:
            1. The patient will be taking the requested agent in combination with methotrexate; **OR**
            2. The patient has an intolerance, FDA labeled contraindication, or hypersensitivity to methotrexate **[medical record documentation required]**; **AND**
        iv. ONE of the following:
            1. The patient has tried and had an inadequate response to at least ONE biologic immunomodulator FDA labeled or supported in compendia for the treatment of RA for at least 3-months **[medical record documentation required]**; **OR**
            2. The patient has an intolerance or hypersensitivity to ONE biologic immunomodulator FDA labeled or supported in compendia for the treatment of RA **[medical record documentation required]**; **OR**

3. The patient has an FDA labeled contraindication to ALL biologic immunomodulators FDA labeled for the treatment of RA **[medical record documentation required]**; **OR**

b. The patient has a diagnosis of **granulomatosis with polyangiitis (GPA) (Wegener's granulomatosis)** or **microscopic polyangiitis (MPA)** [subtypes of ANCA-associated vasculitis]; **AND**
   i. The patient is 2 years of age or older; **AND**
   ii. ONE of the following:
      1. The patient will receive the requested agent in combination with glucocorticoids (e.g., prednisone, methylprednisolone, etc.) **[medical record documentation required]**; **OR**
      2. The patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ALL glucocorticoids (e.g., prednisone, methylprednisolone, etc.) used in the treatment of GPA or MPA **[medical record documentation required]**; **OR**
      3.

c. The patient has a diagnosis of moderate to severe **pemphigus vulgaris (PV)**; **AND**
   i. The patient is 18 years of age or older; **OR**
   ii.

d. The patient has a diagnosis of **autoimmune hemolytic anemia (AIHA)**; **AND**
   i. The patient has warm-reactive disease; **AND**
      1. The patient is refractory to or dependent on glucocorticoids (e.g., prednisone) **[medical record documentation required]**; **OR**
   ii. The patient has cold agglutinin disease; **AND**
      1. The diagnosis has been confirmed by ALL of the following tests **[medical record documentation required]**:
         a. Chronic hemolysis; **AND**
         b. Positive polyspecific direct antiglobulin test (DAT); **AND**
         c. Positive monospecific DAT specific for C3d; **AND**
         d. Cold agglutinin titer ≥64 at 4°C; **AND**
         e. IgG DAT ≤1+; **AND**
      2. The patient has symptomatic anemia, transfusion-dependence, and/or disabling circulatory symptoms **[medical record documentation required]**; **OR**

e. The patient has a diagnosis of **chronic immune (idiopathic) thrombocytopenia (ITP, Evans syndrome)**; **AND**

i. ONE of the following **[medical record documentation required]**:
   1. The patient has a platelet count ≤ 30 x 10^9/L; **OR**
   2. The patient has a platelet count < 50 x 10^9/L AND has symptomatic bleeding and/or an increased risk for bleeding (e.g., ≥60 years old, on anticoagulant or antiplatelet medications, history of bleeding, comorbidities for bleeding [e.g., peptic ulcer disease, uncontrolled hypertension, anemia or low hemoglobin], etc.); **AND**

ii. ONE of the following:
   1. The patient has tried and had an inadequate response to a prior ITP treatment (i.e., glucocorticoids [prednisone, dexamethasone], immunoglobulins [IVIG or anti-D], thrombopoietin receptor agonists [avatrombopag, eltrombopag, romiplostim], or splenectomy) **[medical record documentation required]**; **OR**
   2. The patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ALL other ITP treatment (i.e., glucocorticoids [prednisone, dexamethasone], immunoglobulins [IVIG or anti-D], thrombopoietin receptor agonists [avatrombopag, eltrombopag, romiplostim], and splenectomy) **[medical record documentation required]**; **OR**

f. The patient has a diagnosis of **immune-mediated or acquired thrombotic thrombocytopenic purpura (iTTP)**; **AND**
   i. The diagnosis has been confirmed by severely reduced baseline activity of ADAMTS13 (less than 10%), with the presence of an ADAMTS13 inhibitor or anti-ADAMTS13 IgG **[medical record documentation required]**; **AND**
   ii. ONE of the following:
      1. BOTH of the following:
         a. The requested agent will be used in combination with therapeutic plasma exchange (TPE); **AND**
         b. ONE of the following:
            i. The requested agent will be used in combination with glucocorticoids used in the treatment of iTTP **[medical record documentation required]**; **OR**
            ii. The patient has an intolerance, FDA labeled contraindication, or hypersensitivity to glucocorticoids used in the treatment of iTTP **[medical record documentation required]**; **OR**
      2. The patient is in remission and will be using the requested agent for prevention of relapse; **OR**

g. The patient has a diagnosis of a relapsing form of **multiple sclerosis (MS)**, to include clinically isolated syndrome, relapsing-remitting disease, or active secondary progressive disease; **AND**
   i. The patient will NOT be using the requested agent in combination with an additional disease modifying agent (DMA) used in the treatment of MS; **OR**

h. The patient has a diagnosis of **neuromyelitis optica spectrum disorder (NMOSD)**; **AND**
    i. ONE of the following **[medical record documentation required]**:
        1. The patient is seropositive for aquaporin-4 (AQP4) IgG antibodies; **OR**
        2. The patient is seronegative for AQP4-IgG antibodies OR has unknown AQP4-IgG antibody status; **AND**
    ii. The diagnosis has been confirmed by the presence of the following core clinical characteristics – at least ONE for AQP4-IgG antibody seropositive patients or at least TWO for AQP4-IgG antibody seronegative patients or patients with unknown AQP4-IgG antibody status **[medical record documentation required]**:
        1. Optic neuritis; **OR**
        2. Acute myelitis; **OR**
        3. Area postrema syndrome: Episode of otherwise unexplained hiccups or nausea and vomiting; **OR**
        4. Acute brainstem syndrome; **OR**
        5. Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions; **OR**
        6. Symptomatic cerebral syndrome with NMOSD-typical brain lesions; **AND**
    iii. The patient has had at least ONE attack or relapse in the last 12 months prior to treatment with an immunotherapy or complement inhibitor for NMOSD (e.g., an eculizumab product, inebilizumab, ravulizumab, a rituximab product, satralizumab, etc.) **[medical record documentation required]**; **AND**
    iv. The patient does NOT have any other alternative diagnoses to explain or cause the current disease symptoms (e.g., multiple sclerosis, ischemic optic neuropathy, etc.); **AND**
    v. The patient will NOT be using the requested agent in combination with another biologic immunomodulator agent used in the treatment of NMOSD (e.g., an eculizumab product, inebilizumab, ravulizumab, satralizumab, etc.); **OR**

i. The patient has a diagnosis of **immunoglobulin G4-related disease (IgG4-RD)**; **AND**
    i. The diagnosis has been confirmed by the 2019 American College of Rheumatology (ACR)/European League Against Rheumatism (EULAR) Classification Criteria for IgG4-RD (i.e., fulfillment of entry criteria, lack of any exclusion criteria, and ≥ 20 classification criteria inclusion points) **[medical record documentation required]**; **AND**
    ii. The patient has IgG4-RD affecting two or more organs/sites at any time in the course of disease (e.g., pancreas, major salivary glands, lacrimal glands, bile ducts/biliary tree, orbits, kidneys, lungs, aorta, retroperitoneum, pachymeninges, thyroid gland [Riedel's thyroiditis]) **[medical record documentation required]**; **AND**
    iii. The patient does NOT have any other alternative diagnoses to explain or cause the current disease symptoms (e.g., malignancy, infection, other autoimmune disorders, etc.); **AND**

iv. The patient is experiencing or has recently experienced an IgG4-RD flare that requires initiation or continuation of glucocorticoid treatment, and/or the patient has recurrent disease **[medical record documentation required]**; **AND**
v. ONE of the following:
    1. The patient has tried and had an inadequate response to glucocorticoids (e.g., ≥ 1 flare, new or worsening symptoms, no reduction in mass/organ size, no improvement in organ function, inadequate decreases in serum IgG4 concentrations from glucocorticoids alone) used in the treatment of IgG4-RD **[medical record documentation required]**; **OR**
    2. The patient has an intolerance, FDA labeled contraindication, or hypersensitivity to glucocorticoids used in the treatment of IgG4-RD **[medical record documentation required]**; **AND**
vi. The patient will NOT be using the requested agent in combination with inebilizumab-cdon (Uplizna) used in the treatment of IgG4-RD; **OR**

j. The patient has a diagnosis of **refractory generalized myasthenia gravis (gMG)**; **AND**
    i. The patient has a positive serological test for anti-muscle-specific tyrosine kinase (MuSK) antibodies **[medical record documentation required]**; **AND**
    ii. ONE of the following:
        1. The prescriber has assessed the patient's current medications and discontinued any medications known to exacerbate myasthenia gravis (e.g., beta blockers, procainamide, quinidine, magnesium, anti-programmed death receptor-1 monoclonal antibodies, hydroxychloroquine, aminoglycosides); **OR**
        2. The prescriber has provided clinical rationale indicating that discontinuation of the offending agent is not clinically appropriate **[medical record documentation required]**; **AND**
    iii. ONE of the following:
        1. The patient has tried and had an inadequate response to at least ONE conventional agent used in the treatment of gMG (i.e., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, tacrolimus, methotrexate, cyclophosphamide) **[medical record documentation required]**; **OR**
        2. The patient has an intolerance or hypersensitivity to ONE conventional agent used for the treatment of gMG (i.e., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, tacrolimus, methotrexate, cyclophosphamide) **[medical record documentation required]**; **OR**
        3. The patient has an FDA labeled contraindication to ALL conventional agents used for the treatment of gMG (i.e., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, tacrolimus, methotrexate, cyclophosphamide) **[medical record documentation required]**; **OR**

4. The patient required chronic intravenous immunoglobulin (IVIG) (i.e., at least every 3 months over 12 months without symptom control) **[medical record documentation required]**; **OR**
5. The patient required chronic plasmapheresis/plasma exchange (i.e., at least every 3 months over 12 months without symptom control) **[medical record documentation required]**; **AND**

iv. The patient will NOT be using the requested agent in combination with other immunotherapy or complement inhibitors (e.g., eculizumab products [e.g., Soliris, Bkemv, Epysqli], efgartigimod alfa [Vyvgart, Vyvgart Hytrulo], immunoglobulins, nipocalimab [Imaavy], ravulizumab [Ultomiris], rozanolixizumab [Rystiggo], or zilucoplan [Zilbrysq]) used in the treatment of gMG; **OR**

k. The patient has a diagnosis of **systemic lupus erythematosus (SLE)**; **AND**
   i. The patient has a clinical diagnosis of moderate to severe SLE according to American College of Rheumatology classification criteria **[medical record documentation required]**; **AND**
      1. The patient does NOT have active lupus nephritis (LN); **AND**
   ii. The patient is autoantibody positive with ONE of the following **[medical record documentation required]**:
      1. ANA (anti-nuclear antibody) above the laboratory reference range; **OR**
      2. Anti-dsDNA (double stranded DNA antibody) above the laboratory reference range, or greater than two-fold the reference range if tested by ELISA; **OR**
      3. Anti-Sm (anti-Smith antibody) above the laboratory reference range, or greater than two-fold the reference range if tested by ELISA; **AND**
   iii. ONE of the following:
      1. The patient is currently being treated with hydroxychloroquine AND the patient will continue therapy in combination with the requested agent **[medical record documentation required]**; **OR**
      2. The patient will be initiated on concurrent therapy with hydroxychloroquine **[medical record documentation required]**; **OR**
      3. The patient has a clinical intolerance/contraindication to hydroxychloroquine **[medical record documentation required]**; **AND**
   iv. ONE of the following:
      1. The patient tried and had an inadequate response to ONE corticosteroid or immunosuppressive agent (i.e., azathioprine, methotrexate, mycophenolate, cyclophosphamide) **[medical record documentation required]**; **OR**
      2. The patient has an intolerance or hypersensitivity to ONE corticosteroid or immunosuppressive agent (i.e., azathioprine, methotrexate, mycophenolate, cyclophosphamide) **[medical record documentation required]**; **OR**

3. The patient has an FDA labeled contraindication to ALL corticosteroids AND immunosuppressive agents (i.e., azathioprine, methotrexate, mycophenolate, cyclophosphamide) **[medical record documentation required]**; **AND**

v. The patient will be receiving the requested agent in combination with a standard immunosuppressive therapy regimen for active LN (e.g., azathioprine, cyclophosphamide, corticosteroids, hydroxychloroquine, methotrexate, mycophenolic acid analogs) **[medical record documentation required]**; **AND**

vi. The patient does NOT have severe active central nervous system (CNS) lupus; **AND**

vii. The patient will NOT be using the requested agent in combination with voclosporin (Lupkynis) used in the treatment of SLE; **OR**

l. The patient has a diagnosis of **lupus nephritis (LN)**; **AND**

i. The patient has a clinical diagnosis of SLE according to American College of Rheumatology classification criteria **[medical record documentation required]**; **AND**

ii. The patient has biopsy-proven active lupus nephritis (LN) Class III or IV (with or without Class V LN) **[medical record documentation required]**; **AND**

iii. The patient is autoantibody positive with ONE of the following **[medical record documentation required]**:

1. ANA (anti-nuclear antibody) above the laboratory reference range; **OR**
2. Anti-dsDNA (double stranded DNA antibody) above the laboratory reference range, or greater than two-fold the reference range if tested by ELISA; **OR**
3. Anti-Sm (anti-Smith antibody) above the laboratory reference range, or greater than two-fold the reference range if tested by ELISA; **AND**

iv. ONE of the following:

1. The patient is currently being treated with hydroxychloroquine AND the patient will continue therapy in combination with the requested agent **[medical record documentation required]**; **OR**
2. The patient will be initiated on concurrent therapy with hydroxychloroquine **[medical record documentation required]**; **OR**
3. The patient has a clinical intolerance/contraindication to hydroxychloroquine **[medical record documentation required]**; **AND**

v. The patient will be receiving the requested agent in combination with a standard immunosuppressive therapy regimen for active LN (e.g., azathioprine, cyclophosphamide, glucocorticoids, mycophenolic acid analogs) **[medical record documentation required]**; **AND**

vi. The patient does NOT have severe active central nervous system (CNS) lupus; **OR**

m. The patient has a diagnosis of **idiopathic (primary) membranous nephropathy**; **AND**
    i. The patient does NOT have any other alternative diagnoses to explain or cause the current disease symptoms (e.g., infections, autoimmune diseases, malignancies, nutritional supplements [e.g., lipoic acid, etc.], nonsteroidal anti-inflammatory drugs [NSAIDs], etc.); **AND**
    ii. The requested agent will be used for ONE of the following indications **[medical record documentation required]**:
        1. First-line therapy in patients with ANY of the following moderate to high risk factors for progressive disease:
            a. Proteinuria greater than 3.5 g/day and no decrease greater than 50% after 6 months of therapy with an angiotensin converting enzyme inhibitor (ACEi) or angiotensin II receptor blocker (ARB); **OR**
            b. eGFR less than 60 mL/min/1.73m^2; **OR**
            c. Proteinuria greater than 8 g/day for greater than 6 months; **OR**
            d. The patient has experienced serious complications of nephrotic syndrome (e.g., acute kidney injury, infection, thromboembolic events, etc.); **OR**
        2. Initial disease relapse following remission on first-line therapy with a rituximab product, a calcineurin inhibitor (e.g., tacrolimus, cyclosporine, etc.) or cyclophosphamide in combination with glucocorticoids; **OR**
        3. Treatment-resistance to first-line therapy with a rituximab product, a calcineurin inhibitor (e.g., tacrolimus, cyclosporine, etc.) or cyclophosphamide in combination with glucocorticoids; **AND**
            a. The patient has a stable eGFR; **AND**
            b. The requested agent will be used in combination with a calcineurin inhibitor if previously treated with a rituximab product alone in the first-line setting; **OR**
        4. Disease recurrence following kidney transplant; **AND**
            a. The patient has proteinuria greater than 1 g/day; **OR**

n. The patient has a diagnosis of **pediatric idiopathic nephrotic syndrome**; **AND**
    i. The patient is less than 18 years of age; **AND**
    ii. The patient has symptomatic disease (i.e., nephrotic-range proteinuria [>3.5 g/day] and either hypoalbuminemia [<3.5 g/dL] or edema when albumin level is not available); **AND**
    iii. The patient has been diagnosed with ONE of the following **[medical record documentation required]**:
        1. Frequently relapsing nephrotic syndrome (FRNS) with at least three relapses per year or at least two relapses within 6 months following remission of the initial episode; **OR**

2. Steroid-dependent nephrotic syndrome (SDNS) with two consecutive relapses during steroid therapy (either at full-dose or during tapering) or within 14 days of discontinuation of steroid therapy; **OR**
3. Steroid-resistant nephrotic syndrome (SRNS) with failure to achieve complete remission within a 4-week course of daily corticosteroids; **AND**

iv. ONE of the following:
1. The patient has tried and had an inadequate response to an adequate trial of at least ONE other steroid-sparing agent (e.g., cyclophosphamide, calcineurin inhibitor [e.g., tacrolimus, cyclosporine, etc.], mycophenolate mofetil, etc.) **[medical record documentation required]**; **OR**
2. The patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ALL other steroid-sparing agents (e.g., cyclophosphamide, calcineurin inhibitor [e.g., tacrolimus, cyclosporine, etc.], mycophenolate mofetil, etc.) used in the treatment of pediatric idiopathic nephrotic syndrome **[medical record documentation required]**; **OR**

o. The patient has a diagnosis of **Wiskott-Aldrich syndrome (WAS)**; **AND**
i. The requested agent will be used as pretreatment prior to infusion of etuvetidigene autotemcel (Waskyra) **[medical record documentation required]**; **AND**
ii. The requested agent will be used for ONE of the following:
1. To deplete autoreactive B-cells; **OR**
2. As pre-emptive treatment for potential lymphoproliferative disorder due to Epstein Barr Virus infection; **OR**

p. The patient has a diagnosis of **antisynthetase syndrome-related interstitial lung disease (ASyS-ILD)**; **AND**
i. The patient is 18 years of age or older; **AND**
ii. The patient has antisynthetase antibody positive disease (e.g., anti-Jo-1, anti-PL-7, anti-PL-12, anti-EJ, anti-OJ, etc.) **[medical record documentation required]**; **AND**
iii. The diagnosis has been confirmed by the presence of characteristic features of interstitial lung disease (ILD) on chest high-resolution computed tomography (HRCT); **AND**
iv. The prescribing physician has assessed baseline disease severity using an objective measure (i.e., baseline glucocorticoid use, pulmonary function testing [i.e., forced vital capacity (FVC%), total lung capacity (TLC%), diffusing capacity of the lungs for carbon monoxide (DLCO%)], or chest HRCT scan); **AND**
v. The patient has severe active disease **[medical record documentation required]**; **AND**

vi. The patient has recurrent or progressive disease despite treatment with glucocorticoids and/or other immunosuppressive agents (e.g., azathioprine, mycophenolate mofetil, cyclophosphamide, tacrolimus, etc.) **[medical record documentation required]**; **AND**
vii. ONE of the following:
    1. The requested agent will be used in combination with glucocorticoids or other immunosuppressive agents (e.g., azathioprine, mycophenolate mofetil, cyclophosphamide, tacrolimus, etc.) **[medical record documentation required]**; **OR**
    2. The patient has an intolerance, FDA labeled contraindication, or hypersensitivity to ALL glucocorticoids and immunosuppressive agents used in the treatment of ASyS-ILD **[medical record documentation required]**; **AND**

3. The prescriber is a specialist in the area of the patient's diagnosis (e.g., dermatologist for PV; hematologist for AIHA, ITP, TTP, WAS; immunologist for RA, GPA, MPA, PV, gMG, MS, NMOSD, SLE, LN, WAS; nephrologist for RA, GPA, MPA, SLE, LN, membranous nephropathy, pediatric nephrotic syndrome; neurologist for RA, GPA, MPA, gMG, MS, NMOSD, SLE, LN; pulmonologist for GPA, MPA, ASyS-ILD; rheumatologist for RA, GPA, MPA, ASyS-ILD, IgG4-RD, gMG, MS, NMOSD, SLE, LN, membranous nephropathy, pediatric nephrotic syndrome; etc.) or has consulted with a specialist in the area of the patient's diagnosis; **AND**
4. The patient will NOT be using the requested agent in combination with another biologic immunomodulator agent used in the treatment of the requested indication; **AND**
5. The patient does NOT have any FDA labeled contraindications to the requested agent; **AND**
6. The patient has been screened for hepatitis B infection measuring hepatitis B surface antigen (HBsAg) and hepatitis B core antibody (anti-HBc) AND if positive the patient has begun therapy for hepatitis B; **AND**
7. The requested quantity does NOT exceed the maximum units allowed for the duration of approval (see table below).

Duration of Approval:

Wiskott-Aldrich syndrome: 180 days (6 months); one-time, single-dose treatment per lifetime
All other diagnoses: 365 days (1 year)

Note: This policy only applies to rituximab (Rituxan) and rituximab biosimilars (Riabni, Ruxience, and Truxima) when used for the treatment of non-oncologic indications.

FDA Label Reference				
Medication	**Indication**	**Dosing**	**HCPCS**	**Maximum Units***
rituximab (Rituxan®) intravenous (IV) infusion	Rheumatoid arthritis (RA)	1,000 mg IV on days 1 and 15 (one course) repeated every 24 weeks or based on clinical evaluation, but no sooner than every 16 weeks; given in combination with methotrexate	J9312	Pediatric idiopathic nephrotic syndrome: 300 WAS: 100 (one-time, single-dose per lifetime) All other diagnoses: 600

	Granulomatosis with polyangiitis (GPA) (Wegener's granulomatosis) or Microscopic polyangiitis (MPA)	<u>Induction (pediatric and adult)</u>
		375 mg/m² IV weekly for 4 doses, <u>or</u>
		• Pediatric (up to a maximum of 1,000 mg per dose):
		  ○ 575 mg/m² IV on days 1 and 15 (BSA ≤1.5m²)
		  ○ 750 mg/m² IV on days 1 and 15 (BSA >1.5m²), <u>or</u>
		• Adult: 1,000 mg IV on days 1 and 15 (one course)
		
		<u>Maintenance</u>
		• Pediatric: 250 mg/m² IV on days 1 and 15, then 250 mg/m² every 6 months thereafter based on clinical evaluation
		• Adult: 500 mg to 1,000 mg IV on days 1 and 15, then 500 mg to 1,000 mg every 6 months thereafter based on clinical evaluation		

FDA Label Reference				
Medication	**Indication**	**Dosing**	**HCPCS**	**Maximum Units***
		*Initial maintenance infusions should be no sooner than 16 weeks and no later than 24 weeks after the previous infusion if rituximab was used for initial induction therapy. *Initial maintenance infusions should be initiated within 4 weeks following disease control when initial induction occurred with other standard of care immunosuppressants.		
	Pemphigus vulgaris (PV)	Initiation 1,000 mg IV on days 1 and 15, or 375 mg/m² IV weekly for 4 doses Maintenance 500 mg IV at month 12 and repeat every 6 months thereafter or based on clinical evaluation Relapse 1,000 mg IV upon relapse, resumption of glucocorticoids may be considered *Subsequent infusions (maintenance and relapse) should be no sooner than 16 weeks after the previous infusion		

FDA Label Reference				
Medication	**Indication**	**Dosing**	**HCPCS**	**Maximum Units***
	Autoimmune hemolytic anemia (AIHA)	Warm-reactive disease 375 mg/m² IV weekly for 4 doses every 6 months, or 1,000 mg on days 1 and 15 every 6 months Cold agglutinin disease 375 mg/m² IV weekly for 4 doses every 6 months		
rituximab-arrx (Riabni®) intravenous (IV) infusion	Immune (idiopathic) thrombocytopenia (ITP, Evans syndrome) or Thrombotic thrombocytopenic purpura (iTTP)	375 mg/m² IV weekly for 4 doses every 6 months, or 1,000 mg IV on days 1 and 15 every 6 months	Q5123	Pediatric idiopathic nephrotic syndrome: 300 WAS: 100 (one-time, single-dose per lifetime) All other diagnoses: 600
	Multiple sclerosis (MS)	1,000 mg IV on days 1 and 15, repeat every 6 months		
	Neuromyelitis optica spectrum disorder (NMOSD)	1,000 mg IV once on days 1 and 15, repeat every 6 months; or 375 mg/m^2 once weekly for 4 weeks, repeat every 6 months		
rituximab-pvvr (Ruxience®)	Immunoglobulin G4-related disease (IgG4-RD)	Induction 375 mg/m^2 IV once weekly for 1-4 doses, or 1,000 mg IV on days 1 and 15	Q5119	Pediatric idiopathic nephrotic syndrome: 300

FDA Label Reference				
Medication	**Indication**	**Dosing**	**HCPCS**	**Maximum Units***
intravenous (IV) infusion		*Subsequent infusions (maintenance and relapse) may be administered at either induction schedule above and should be repeated no sooner than every 6 months.		WAS: 100 (one-time, single-dose per lifetime) All other diagnoses: 600
	Refractory generalized myasthenia gravis (gMG)	1,000 mg IV on days 1 and 15, may repeat a full or partial course every 6 months; or 375 mg/m^2 IV once weekly for 4 doses, may repeat a full or partial course every 6 months		
	Systemic lupus erythematosus (SLE) or Lupus nephritis (LN)	1,000 mg IV on days 1 and 15 every 6 months, or 375 mg/m^2 IV once weekly for 4 doses every 6 months		
rituximab-abbs (Truxima®) intravenous (IV) infusion	Idiopathic (primary) membranous nephropathy	375 mg/m^2 IV once weekly for 1-4 doses every 6 months, or 1,000 mg IV on days 1 and 15 every 6 months	Q5115	Pediatric idiopathic nephrotic syndrome: 300 WAS: 100 (one-time, single-dose per lifetime) All other diagnoses: 600
	Pediatric idiopathic nephrotic syndrome	375 mg/m^2 IV once weekly for 1-4 doses		
	Wiskott-Aldrich syndrome (WAS)	375 mg/m^2 IV as a single dose approximately 22 days prior to etuvetidigene autotemcel administration		

FDA Label Reference				
Medication	**Indication**	**Dosing**	**HCPCS**	**Maximum Units***
	Antisynthetase syndrome-related interstitial lung disease (ASyS-ILD)	1,000 mg IV on days 1 and 15 repeated every 6 months, or 375 mg/m^2 IV once weekly for 4 doses repeated every 6 months		

***Maximum units allowed for duration of approval**

Other codes that may applicable to this policy:

Diagnoses that are subject to medical necessity review: D59.10, D59.11, D59.12, D59.13, D59.19, D69.3, D69.41, D82.0, D89.84, G35.A, G36.0, G70.00, G70.01, J84.170, L10.0, M05.00, M05.011, M05.012, M05.019, M05.021, M05.022, M05.029, M05.031 M05.032, M05.039, M05.041, M05.042, M05.049, M05.051, M05.052, M05.059, M05.061, M05.062, M05.069, M05.071, M05.072, M05.079, M05.09, M05.10, M05.111, M05.112, M05.119, M05.30, M05.311, M05.312, M05.319, M05.321, M05.322, M05.329, M05.331, M05.332, M05.339, M05.341, M05.342, M05.349, M05.351, M05.352, M05.359, M05.361, M05.362, M05.369, M05.371, M05.372, M05.379, M05.39, M05.60, M05.611, M05.612, M05.619, M05.621, M05.622, M05.629, M05.631, M05.632, M05.639, M05.641, M05.642, M05.649, M05.651, M05.652, M05.659, M05.661, M05.662, M05.669, M05.671, M05.672, M05.679, M05.69, M05.A, M06.4, M06.80, M06.811, M06.812, M06.819, M06.821, M06.822, M06.829, M06.831, M06.832, M06.839, M06.841, M06.842, M06.849, M06.851, M06.852, M06.859, M06.861, M06.862, M06.869, M06.871, M06.872, M06.879, M06.88, M06.89, M06.9, M08.00, M08.011, M08.012, M08.019, M08.021, M08.022, M08.029, M08.031, M08.032, M08.039, M08.041, M08.042, M08.049, M08.051, M08.052, M08.059, M08.061, M08.062, M08.069, M08.071, M08.072, M08.079, M08.08, M08.09, M08.20, M08.211, M08.212, M08.219, M08.221, M08.222, M08.229, M08.231, M08.232, M08.239, M08.241, M08.242, M08.249, M08.251, M08.252, M08.259, M08.261, M08.262, M08.269, M08.271, M08.272, M08.279, M08.28, M08.29, M08.40, M08.411, M08.412, M08.419, M08.421, M08.422, M08.429, M08.431, M08.432, M08.439, M08.441, M08.442, M08.449, M08.451, M08.452, M08.459, M08.461, M08.462, M08.469, M08.471, M08.472, M08.479, M08.48, M12.00, M12.011, M12.012, M12.019, M12.021, M12.022, M12.029, M12.031, M12.032, M12.039, M12.041, M12.042, M12.049, M12.051, M12.052, M12.059, M12.061, M12.062, M12.069, M12.071, M12.072, M12.079, M12.08, M12.09, M31.19, M31.30, M31.31, M31.7, M32.14, M32.9, M45.A0, M45.A1, M45.A2, M45.A3, M45.A4, M45.A5, M45.A6, M45.A7, M45.A8, M45.AB, M45.0, M45.1, M45.2, M45.3, M45.4, M45.5, M45.6, M45.7, M45.8, M45.9, N04.21

References: all information referenced is from FDA package insert unless otherwise noted below.

1. Fraenkel L, Bathon JM, England BR, et al. 2021 American College of Rheumatology guideline for the treatment of rheumatoid arthritis. *Arthritis Care & Research*. 2021;73(7):924-39.

2. Singh JA, Furst DE, Bharat A, et al. 2012 update of the 2008 American College of Rheumatology recommendations for the use of disease-modifying antirheumatic drugs and biologic agents in the treatment of rheumatoid arthritis. *Arthritis Care Res*. 2012;64(5):625-639.
3. Singh JA, Saag KG, Bridges SL, Jr., et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Arthritis Rheumatol*. 2016;68(1):1-26.

Policy Implementation/Update Information: Criteria and treatment protocols are reviewed annually by the Blue Cross NC P&T Committee, regardless of change. This policy is reviewed in Q1 annually.

July 2026: Criteria change: Added the following non-oncologic indications to policy with associated criteria and required trial and failure of preferred rituximab biosimilar products (i.e., Riabni, Ruxience, and Truxima): granulomatosis with polyangiitis (GPA) (Wegener's granulomatosis) and microscopic polyangiitis (MPA) [subtypes of ANCA-associated vasculitis]; moderate to severe pemphigus vulgaris (PV); autoimmune hemolytic anemia (AIHA), including cold agglutinin disease; immune (idiopathic) thrombocytopenia (ITP, Evans syndrome), chronic; immune-mediated or acquired thrombotic thrombocytopenic purpura (iTTP); multiple sclerosis (MS), relapsing forms; neuromyelitis optica spectrum disorder (NMOSD); immunoglobulin G4-related disease (IgG4-RD); generalized myasthenia gravis (gMG), refractory; systemic lupus erythematosus (SLE); lupus nephritis (LN); idiopathic (primary) membranous nephropathy; pediatric idiopathic nephrotic syndrome; Wiskott-Aldrich syndrome; antisynthetase syndrome-related interstitial lung disease. Added applicable dosing and associated maximum units within dosing reference table for each indication. Added associated ICD-10 codes to policy subject to medical necessity review: D59.10, D59.11, D59.12, D59.13, D59.19, D69.3, D69.41, D82.0, D89.84, G35.A, G36.0, G70.00, G70.01, J84.170, L10.0, M05.A (effective 10/1/2025), M31.19, M31.30, M31.31, M31.7, M32.14, M32.9, and N04.21. Changed policy name to "Rituximab (Rituxan) and Rituximab Biosimilars for the Treatment of Non-Oncologic Indications" from "Rituximab for the Treatment of Rheumatoid Arthritis". **Policy notification given 4/2/2026 for effective date 7/1/2026**.
January 2026: Criteria change: Changed requirement for trial and failure of preferred rituximab biosimilar products to include Riabni in addition to existing preferred Ruxience and Truxima; adjusted non-preferred rituximab products to include Rituxan. Adjusted verbiage for methotrexate trial option to indicate that inadequate response to methotrexate includes maximally tolerated dosing for at least 3-months. Listed examples of agents for trial option of other conventional agents used in the treatment of RA and added trial duration for at least 3-months. Added additional allowance within conventional trial verbiage for intolerance/hypersensitivity/contraindication to conventional agents used in the treatment of RA. Adjusted verbiage for required trial and failure of one or more TNF inhibitor to indicate at least one biologic immunomodulator FDA labeled or compendia supported for the treatment of RA for at least 3 months, and added allowance for intolerance/hypersensitivity to at least one biologic immunomodulator for treatment of RA. Added requirements to be prescribed by or in consultation with a specialist, no contraindication to the requested agent, and for hepatitis B screening. Other formatting changes made throughout policy and dosing reference table for clarity. **Policy notification given 11/1/2025 for effective date 1/1/2026**.
September 2024: Criteria change: Updated requirement for use of preferred rituximab biosimilars (Truxima and Ruxience) prior to Rituxan or non-preferred rituximab biosimilars to also allow for trial and failure of both preferred rituximab biosimilars OR presence of an intolerance,

FDA labeled contraindication, or hypersensitivity to all preferred rituximab biosimilar products that is NOT expected to occur with the requested product. Updated references.
October 2021: Coding update: Added the following applicable diagnosis codes to policy effective 10/1/2021: M45.A0, M45.A1, M45.A2, M45.A3, M45.A4, M45.A5, M45.A6, M45.A7, M45.A8, and M45.AB.
July 2021: Coding update: Added HCPCS code Q5123 to dosing reference table effective 7/1/2021, deleted non-specific codes C9399, J3490, and J3590 termed 6/30/2021.
June 2021: Criteria change: Medical record documentation required for trial and failure of preferred and conventional agents.
June 2021: Criteria change: Added maximum units; medical policy formatting change. **Policy notification given 4/16/2021 for effective date 6/16/2021**.
*Further historical criteria changes and updates available upon request from Medical Policy and/or Corporate Pharmacy.