Rituximab (Riabni®, Rituxan®, Ruxience®, & Truxima®) (for Ohio Only)

Policy Number: CSOH2024D0003.A
Effective Date: January 1, 2024

↩ **Instructions for Use**

Related Policy
• Oncology Medication Clinical Coverage (for Ohio Only)

Application

This Medical Benefit Drug Policy only applies to the state of Ohio. Any requests for services that are stated as unproven or services for which there is a coverage or quantity limit will be evaluated for medical necessity using Ohio Administrative Code 5160-1-01.

Coverage Rationale

This policy refers only to the following drug products, rituximab injections for intravenous infusion for non-oncology conditions:

- Riabni® (rituximab-arrx)
- Rituxan®(rituximab)
- Ruxience®(rituximab-pvvr)
- Truxima®(rituximab-abbs)
- Any FDA-approved rituximab biosimilar product not listed here

"Rituximab" will be used to refer to all rituximab products without hyaluronidase.

For oncology indications, refer to the Medical Benefit Drug Policy titled Oncology Medication Clinical Coverage (for Ohio Only) for updated information based on the National Comprehensive Cancer Network (NCCN) Drugs & Biologics Compendium.

Riabni® (rituximab-arrx), Rituxan®(rituximab), Ruxience®(rituximab-pvvr), and Truxima®(rituximab-abbs) are proven and medically necessary for the treatment of certain conditions outlined within the InterQual® criteria. For medical necessity clinical coverage criteria for non-oncology indications, refer to the current release of the InterQual® guideline for:

- Riabni: CP: Specialty Rx Non-Oncology, Rituximab-arrx (Riabni)
- Rituxan: CP: Specialty Rx Non-Oncology, Rituximab (Rituxan)
- Ruxience: CP: Specialty Rx Non-Oncology, Rituximab-pvvr (Ruxience)
- Truxima: CP: Specialty Rx Non-Oncology, Rituximab-abbs (Truxima)

Click here to view the InterQual® criteria.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPCS Code	Description
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

Policy History/Revision Information

Date	Summary of Changes

01/01/2024	**Template Update**
	• Created state-specific policy version
	
	Application
	• Modified language to indicate this Medical Benefit Drug Policy only applies to the state of Ohio; any requests for services that are stated as unproven or services for which there is a coverage or quantity limit will be evaluated for medical necessity using *Ohio Administrative Code 5160-1-01*
	
	Coverage Rationale
	• Revised language to indicate:
	  o This policy refers only to the following rituximab injections for intravenous infusion for non-oncology conditions:
	    ▪ Riabni® (rituximab-arrx)
	    ▪ Rituxan®(rituximab)
	    ▪ Ruxience®(rituximab-pvvr)
	    ▪ Truxima®(rituximab-abbs)
	    ▪ Any FDA-approved rituximab biosimilar product not listed here
	  o "Rituximab" will be used to refer to all rituximab products without hyaluronidase
	  o For oncology indications, refer to the Medical Benefit Drug Policy titled *Oncology Medication Clinical Coverage (for Ohio Only)* for updated information based on the National Comprehensive Cancer Network (NCCN) Drugs & Biologics Compendium
	  o Riabni® (rituximab-arrx), Rituxan®(rituximab), Ruxience® (rituximab-pvvr), and Truxima® (rituximab-abbs) are proven and medically necessary for the treatment of certain conditions outlined within the InterQual® criteria; for medical necessity clinical coverage criteria for non-oncology indications, refer to the current release of the InterQual® CP: Specialty Rx Non-Oncology:
	    ▪ Rituximab-arrx (Riabni)
	    ▪ Rituximab (Rituxan)
	    ▪ Rituximab-pvvr (Ruxience)
	    ▪ Rituximab-abbs (Truxima)
	
	Applicable Codes
	• Removed HCPCS code J9311
	• Removed list of applicable ICD-10 diagnosis codes
	
	Supporting Information
	• Removed *Background*, *Clinical Evidence*, *FDA*, and *References* sections
	• Archived previous policy version CS2022D0003AI

This Medical Benefit Drug Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state [Ohio Administrative Code (OAC)], or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state (OAC), or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state (OAC), or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state (OAC), or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Benefit Drug Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Benefit Drug Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

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