

PRIOR AUTHORIZATION REQUEST FORM

Tyenne (tocilizumab-aazg) and Biosimilars

For authorization, please answer each question and fax this form PLUS chart notes back to RealRx Medicaid Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call Pharmacy Customer Service for assistance.

- Healthy U: 855-856-5694
- Healthy U CHIP: 855-203-3633
- Health Choice Utah: 855-864-1404

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

| | | |
|---------------|--------------|-----------------|
| Date: | Member Name: | ID#: |
| DOB: | Gender: | Physician: |
| Office Phone: | Office Fax: | Office Contact: |

Height/Weight:

Preferred: Tyenne

Non-preferred: Actemra, Avtozma, Tofidence

Product Requested: _____

Directions for Use: _____

| PART I: Criteria for Approval: (All of the following criteria must be met) - Then move to PART II | Yes | No |
|---|--------------------------|--------------------------|
| 1. Which medication is being requested? <input type="checkbox"/> Tyenne (Preferred) <input type="checkbox"/> Other tocilizumab brand or biosimilar (non-preferred) (Part III Required) <input type="checkbox"/> Actemra for SSc-ILD (non-preferred, Part III not required) | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Is the medication being prescribed by or in consultation with a provider specializing in the disease treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Does the patient have any of the following diagnoses? (check the applicable) <input type="checkbox"/> Giant Cell Arteritis (GCA) <input type="checkbox"/> Polyarticular Juvenile Idiopathic Arthritis (JIA) <input type="checkbox"/> Rheumatoid Arthritis (RA) <input type="checkbox"/> Systemic Juvenile Idiopathic Arthritis (JIA) <input type="checkbox"/> Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD) (Actemra only) <input type="checkbox"/> Other - (specify): _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Does the requested medication and diagnosis follow FDA-approved age, dosing, monitoring and contraindications? If answer is No, go to Part II, section 5 | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Does the provider attest that the patient is not taking concurrent treatment or that the medication will not be used in combination with other TNF-inhibitor, biologic response modifier or other biologic DMARDs, Janus kinase Inhibitors, or Phosphodiesterase 4 inhibitor (i.e., apremilast, tofacitinib, baricitinib) as verified by prescriber attestation, member medication fill history, or submitted documentation? | <input type="checkbox"/> | <input type="checkbox"/> |

PART II: Select and fill out applicable sections:

Section 1: Additional criteria for Giant Cell Arteritis (All of the following criteria must be met)

| | | |
|--|--------------------------|--------------------------|
| 1. Is the patient at least 18 years of age or older? | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

| | | |
|---|--------------------------|--------------------------|
| 2. Does the patient have a diagnosis of giant cell arteritis confirmed by biopsy or imaging demonstrated by description of baseline symptoms present in the chart notes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Will the requested medication be used in combination with a tapering course of glucocorticoids? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has the patient tried and failed for at least 3 months, demonstrated an intolerance to, or has a contraindication to methotrexate, if clinically appropriate? | <input type="checkbox"/> | <input type="checkbox"/> |
| Section 2: Additional criteria for Polyarticular Juvenile Idiopathic Arthritis or Systemic Juvenile Idiopathic Arthritis (JIA) (All of the following criteria must be met) | | |
| 1. Is the patient at least 2 years of age or older? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the patient have a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis or systemic juvenile idiopathic arthritis demonstrated by description of baseline symptoms present in the chart notes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has the patient tried and failed, demonstrated an intolerance to or has a contraindication to one NSAID or glucocorticoid for 3 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has the patient tried and failed, demonstrated an intolerance to, or has a contraindication to methotrexate or leflunomide for 3 months, if clinically appropriate? | <input type="checkbox"/> | <input type="checkbox"/> |
| Section 3: Additional criteria for Rheumatoid Arthritis (RA) (All of the following criteria must be met) | | |
| 1. Is the patient at least 18 years of age or older? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the patient have a diagnosis of moderately to severely active rheumatoid arthritis demonstrated by description of baseline symptoms present in the chart notes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has the member tried and failed, demonstrated an intolerance to at least one disease modifying antirheumatic drug (DMARD) for at least 3 months (e.g. hydroxychloroquine, leflunomide, methotrexate, sulfasalazine) or contraindication to all, if clinically appropriate? | <input type="checkbox"/> | <input type="checkbox"/> |
| Section 4: Additional criteria for Systemic Sclerosis-Associated Interstitial Lung Disease (All of the following criteria must be met) | | |
| 1. Is the patient at least 18 years of age or older? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the patient have a diagnosis of Systemic Sclerosis-Associated Interstitial Lung Disease demonstrated by description of baseline symptoms present in the chart notes? | <input type="checkbox"/> | <input type="checkbox"/> |
| Section 5: Other - Off Label or Compendia Use of FDA-Approved Drugs Additional Criterion: | | |
| 1. Does the clinical documentation show an adequate trial and failure with at least ONE FDA-labeled and Medicaid preferred medication, if applicable? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Provider attest the requested drug is being used for a medically accepted indication that is supported by information from the appropriate compendia* of current literature. Including at least (1) major multi-site study or three (3) smaller studies published in JAMA, NEJM, Lancet, or other peer review specialty medical journals in the most recent years? * Compendia use must be recommended by generally accepted compendia such as American Hospital Formulary Service Drug Information (AHFS), United States Pharmacopeia-Drug Information (USP-DI), the Micromedex Information System, Pediatric and Neonatal Lexi-Drugs, or clinical guidelines. | <input type="checkbox"/> | <input type="checkbox"/> |
| PART III: Non-Preferred adalimumab Criteria (PART 1 & PART II MUST also be met) | | |
| 1. For requests of brand Actemra or non-preferred biosimilar, has the patient tried and failed the preferred tocilizumab products? | <input type="checkbox"/> | <input type="checkbox"/> |
| Reauthorization | | |
| 1. Has the provider submitted updated chart notes demonstrating positive clinical response? | <input type="checkbox"/> | <input type="checkbox"/> |
| PRESCRIBER CERTIFICATION | | |
| I hereby certify this treatment is indicated, necessary and meets the guidelines for use. | | |
| Physician's Signature: | Date: | |

Initial Authorization: Up to six (6) months

Reauthorization: Up to one (1) year

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Note:

- WARNING: SERIOUS INFECTIONS AND MALIGNANCY
 - SERIOUS INFECTIONS

- Patients treated with tocilizumab products including TYENNE are at increased risk for developing serious infections that may lead to hospitalization or death. Most patients who developed these infections were taking concomitant immunosuppressants such as methotrexate or corticosteroids.
- If a serious infection develops, interrupt TYENNE until the infection is controlled.

Policy: PHARM-HYB-190

Origination Date: 01/01/2026

Reviewed/Revised Date:

Next Review Date:

Current Effective Date: 01/01/2026

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