



9/9/2026	<%PANumber%>
Prior Authorization	
Internal Use Only	
JOHNS HOPKINS HEALTH PLANS Tyenne - Priority Partners MCO	
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at 1-410-424-4607. Please contact Johns Hopkins Health Plans at 1-888-819-1043 with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of Tyenne - Priority Partners MCO.	

Drug Name (select from list of drugs shown)		
Tyenne Injection (tocilizumab-aazg)		
Quantity	Frequency	Strength
Route of Administration	Expected Length of Therapy	

Patient Information	
Patient Name:	_____
Patient ID:	_____
Patient Group No.:	_____
Patient DOB:	_____
Patient Phone:	_____

Prescribing Physician	
Physician Name:	_____
Physician Phone:	_____
Physician Fax:	_____
Physician Address:	_____
City, State, Zip:	_____

Diagnosis: _____	ICD Code: _____
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Comments: _____

Please circle the appropriate answer for each question.	
1. Will the requested medication be used for any other uses that are not Food and Drug Administration (FDA)-approved or guideline-supported?	☐ Y ☐ N
NOTE: Submission of medical records is required.	

[If yes, no further questions.]	
2. Will the requested medication be used concurrently with another biologic disease modifying anti-rheumatic drug (DMARD)?	Y N
[If yes, no further questions.]	
3. Does the patient have any of the following diagnoses: A) sarcoidosis, B) graft-versus-host disease, C) interleukin-2 toxicity, D) Langerhans cell histiocytosis, E) myositis, F) nephrotic syndrome, G) amyloidosis, H) periodic fever syndrome, I) renal transplant syndrome, J) moderate to severe Crohn's disease in pediatric patients as first line therapy, or K) definitive radiographic axial spondyloarthritis with evidence of structural damage on sacroiliac joints?	Y N
[If yes, no further questions.]	
4. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)?	Y N
NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.	
[If no, skip to question 11.]	
5. Does the patient have a diagnosis of one of the following: A) rheumatoid arthritis, or B) juvenile idiopathic arthritis?	Y N
NOTE: Submission of medical records is required.	
[If no, skip to question 7.]	
6. Is the patient experiencing clinical improvement from treatment supported by one of the following condition indicated outcomes: A) reduction in the signs and symptoms, B) prolonged beneficial clinical response, C) inhibition of structural damage progression, or D) improved physical functioning?	Y N
NOTE: Submission of medical records is required.	
[If yes, skip to question 10.]	
[If no, no further questions.]	
7. Does the patient have a diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD)?	Y N
NOTE: Submission of medical records is required.	
[If no, skip to question 9.]	
8. Is there documentation showing the patient's clinical improvement from treatment as supported by less than or equal to a 10 percent decrease in predicted forced vital capacity?	Y N
NOTE: Submission of medical records is required.	
[If yes, skip to question 10.]	
[If no, no further questions.]	

9. Does the patient have a diagnosis of giant cell arteritis (GCA)?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
10. Is the requested drug prescribed for a Food and Drug Administration (FDA)-approved dosages and dosing intervals?	Y N
NOTE: Submission of medical records is required.	
[No further questions.]	
11. Has the patient previously received biologic therapy?	Y N
[If yes, skip to question 14.]	
12. Has the patient undergone tuberculosis screening within the past year?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
13. Does the patient have an active tuberculosis infection prior to starting the requested biologic therapy?	Y N
NOTE: Submission of medical records is required.	
[If yes, no further questions.]	
14. Does the patient have a diagnosis of moderately to severely active rheumatoid arthritis?	Y N
NOTE: Submission of medical records is required.	
[If no, skip to question 19.]	
15. Has the patient tried and had an insufficient response to at least two formulary disease-modifying antirheumatic drugs (DMARDs) including methotrexate?	Y N
NOTE: Submission of medical records is required.	
[If yes, skip to question 17.]	
16. Does the patient have a contraindication to at least two formulary disease-modifying antirheumatic drugs (DMARDs) including methotrexate?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
17. Has the patient tried and had an insufficient response to at least two of the following: etanercept, a preferred adalimumab product, or sarilumab?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
18. Is the patient 18 years of age or older?	Y N
[If yes, skip to question 35.]	
19. Does the patient have a diagnosis of juvenile idiopathic arthritis?	Y N

NOTE: Submission of medical records is required.	
[If no, skip to question 25.]	
20. Has the patient tried and had an insufficient response to an adequate trial of full dose nonsteroidal anti-inflammatory drug (NSAID) therapy?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
21. Has the patient tried and had insufficient response to at least two disease-modifying antirheumatic drugs (DMARDs) including methotrexate?	Y N
NOTE: Submission of medical records is required.	
[If yes, skip to question 23.]	
22. Does the patient have a contraindication to at least two disease-modifying antirheumatic drugs (DMARDs) including methotrexate?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
23. Has the patient tried and had insufficient response with both etanercept and a preferred adalimumab product?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
24. Is the patient 2 years of age or older?	Y N
[If yes, skip to question 35.]	
25. Does the patient have a diagnosis of giant cell arteritis (GCA)?	Y N
NOTE: Submission of medical records is required.	
[If no, skip to question 28.]	
26. Has the patient tried and had an insufficient response to one systemic corticosteroid?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
27. Is the patient 18 years of age or older?	Y N
[If yes, skip to question 35.]	
28. Does the patient have a diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD)?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
29. Has the diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD) been confirmed through a chest high-resolution computed tomography (HRCT) scan showing ground glass opacification or fibrosis?	Y N
NOTE: Submission of medical records is required.	

[If no, no further questions.]	
30. Does the patient have elevated acute phase reactants, defined as at least ONE of the following: A) C-reactive protein (CRP) greater than or equal to 6 mg/mL, B) erythrocyte sedimentation rate (ESR) greater than or equal to 28 mm/h, OR C) platelet count greater than or equal to 330 x 10 ⁹ /L?	☐ Y ☐ N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
31. Does the patient have a forced vital capacity (FVC) greater than 55 percent of the predicted value?	☐ Y ☐ N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
32. Has the patient tried and had an insufficient response to mycophenolate mofetil?	☐ Y ☐ N
NOTE: Submission of medical records is required.	
[If yes, skip to question 34.]	
33. Does the patient have a contraindication to mycophenolate mofetil?	☐ Y ☐ N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
34. Is the patient 18 years of age or older?	☐ Y ☐ N
[If no, no further questions.]	
35. Is the requested drug prescribed for Food and Drug Administration (FDA)-approved dosages and dosing intervals?	☐ Y ☐ N
NOTE: Submission of medical records is required.	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date