TRICARE Prior Authorization Request Form for
Tocilizumab-aazg (Tyenne Autoinjector, syringe)

JOHNS HOPKINS
HEALTH PLANS
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Does the provider acknowledge the Department of Defense's preferred targeted immune biologic is Humira?	☐ Acknowledged proceed to question **2**	
2. What is the indication or diagnosis?	☐ moderate to severely active rheumatoid arthritis – proceed to question **3** ☐ Giant cell arteritis – proceed to question **11** ☐ Systemic sclerosis-associated lung disease (SSc-ILD) – proceed to question **11** ☐ Active polyarticular Juvenile Idiopathic Arthritis (pJIA) – proceed to question **3** ☐ systemic Juvenile Idiopathic Arthritis (sJIA) – proceed to question **11** ☐ Other indication or diagnosis **–** proceed to question **10**	
3. Has the patient had an inadequate response to at least 1 or more disease modifying anti-rheumatic drugs (DMARDS) non-biologic systemic therapy. (For example: methotrexate, aminosalicylates [for example, sulfasalazine, mesalamine], corticosteroids, immunosuppressants [for example, azathioprine])?	☐ Yes proceed to question **6**	☐ No proceed to question **4**

4. Has the patient had an intolerance to at least 1 or more disease modifying anti-rheumatic drugs (DMARDS) non-biologic systemic therapy. (For example: methotrexate, aminosalicylates [for example, sulfasalazine, mesalamine], corticosteroids, immunosuppressants [for example, azathioprine])?	☐ Yes proceed to question **6**	☐ No proceed to question **5**
5. Does the patient have a contraindication to at least 1 or more disease modifying anti-rheumatic drugs (DMARDS) non-biologic systemic therapy. (For example: methotrexate, aminosalicylates [for example, sulfasalazine, mesalamine], corticosteroids, immunosuppressants [for example, azathioprine])?	☐ Yes proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Humira is the Department of Defense's preferred targeted immune biologic. Has the patient tried Humira?	☐ Yes proceed to question **7**	☐ No proceed to question **9**
7. Has the patient had an inadequate response to Humira?	☐ Yes proceed to question **11**	☐ No proceed to question **8**
8. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent	☐ Yes proceed to question **11**	☐ No proceed to question **9**
9. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes proceed to question **11**	☐ No **STOP** **Coverage not approved**
10. Please provide appropriate literature-based support documentation for the indication and utilization	_____ **STOP** **Coverage not approved**	

11. Will the patient be receiving other targeted immunomodulatory biologics with Tyenne, including but not limited to the following: certolizumab (Cimzia), etanercept (Enbrel), golimumab (Simponi), infliximab (Remicade), apremilast (Otezla), ustekinumab (Stelara), abatacept (Orencia), anakinra (Kineret), tocilizumab (Actemra), tofacitinib (Xeljanz/Xeljanz XR), rituximab (Rituxan), secukinumab (Cosentyx), ixekizumab (Taltz), brodalumab (Siliq), sarilumab (Kevzara), guselkumab (Tremfya), baricitinib (Olumiant), tildrakizumab (Ilumya), risankizumab (Skyrizi), or upadacitinib (Rinvoq ER)?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[13 November 2024]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: