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

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? Call 1-877-880-7007
https://www.usfamilyhealth.org/for-providers/pharmacy-information/

Prior authorization does not expire.

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 **10** ☐ Systemic sclerosis-associated lung disease (SSc-ILD) – proceed to question **10** ☐ Active polyarticular Juvenile Idiopathic Arthritis (pJIA) – proceed to question **3** ☐ systemic Juvenile Idiopathic Arthritis (sJIA) – proceed to question **10** ☐ Other indication or diagnosis **– STOP – Coverage not approved**	
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 **10**	☐ 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 **10**	☐ No proceed to question **9**
9. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. 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