PA Request Criteria

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 3/31/2025
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **NPI#:** **Patient Phone:** _____ **Physician Name:**
Specialty:
Physician Office Telephone:
Physician Office Address: _____

Drug Name (specify drug) _____

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please check the appropriate answer for each applicable question.

1. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Otezla, Xeljanz)? **Y** ☐ **N** ☐

2. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis (TB)? **Y** ☐ **N** ☐

3. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [TST], interferon-release assay [IGRA]) within 6 months of initiating therapy? **Y** ☐ **N** ☐

4. What were the results of the tuberculosis (TB) test?
   - Positive for TB (If checked, go to 5) ☐
   - Negative for TB (If checked, go to 6) ☐
   - Unknown (If checked, no further questions) ☐

5. Which of the following applies to the patient?
   - Patient has latent TB and treatment for latent TB has been initiated (If checked, go to 6) ☐
   - Patient has latent TB and treatment for latent TB has been completed (If checked, go to 6) ☐
   - Patient has latent TB and treatment for latent TB has not been initiated (If checked, no further questions) ☐
   - Patient has active TB (If checked, no further questions) ☐

6. What is the diagnosis?
   - Rheumatoid arthritis (If checked, go to 7) ☐
   - Polyarticular juvenile idiopathic arthritis (pJIA) (If checked, go to 18) ☐
   - Oligoarticular juvenile idiopathic arthritis (If checked, go to 18) ☐
   - Systemic juvenile idiopathic arthritis (sJIA) (If checked, go to 31) ☐
   - Giant cell arteritis (If checked, go to 64) ☐
   - Systemic sclerosis-associated interstitial lung disease (SSc-ILD) (If checked, go to 80) ☐
   - Unicentric Castleman disease (If checked, go to 40) ☐

Multicentric Castleman disease (If checked, go to 50) ☐

Immune checkpoint inhibitor-related inflammatory arthritis (If checked, go to 56) ☐

Cytokine release syndrome (If checked, go to 72) ☐

Acute graft versus host disease (If checked, go to 77) ☐

Polymyalgia rheumatica (If checked, go to 85) ☐

Other, please specify. (If checked, no further questions) ☐

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7. Has the patient been diagnosed with moderately to severely active rheumatoid arthritis (RA)? **Y** ☐ **N** ☐

8. Is the patient an adult (18 years of age or older)? **Y** ☐ **N** ☐

9. Is the requested drug being prescribed by or in consultation with a rheumatologist? **Y** ☐ **N** ☐

10. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug? **Y** ☐ **N** ☐

11. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

Yes (If checked, go to 15) ☐

No (If checked, go to 12) ☐

Unknown (If checked, go to 15) ☐

12. Has the patient achieved or maintained a positive clinical response since starting treatment with the requested drug or a biosimilar of the requested drug? **Y** ☐ **N** ☐

13. Has the patient experienced substantial disease activity improvement (e.g., at least 20% from baseline) in tender joint count, swollen joint count, pain, or disability? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting positive clinical response and substantial disease activity improvement. **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation

14. Is this a request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose or frequency? **Y** ☐ **N** ☐

15. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) indicated for the treatment of moderately to severely active rheumatoid arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried. **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation

16. Does the patient meet either of the following: a) the patient was tested for the rheumatoid factor (RF) biomarker and the RF biomarker test was positive, or b) the patient was tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker and the anti-CCP biomarker test was positive? ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing. **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation

17. Has the patient been tested for all of the following biomarkers: a) rheumatoid factor (RF), b) anti-cyclic citrullinated peptide (anti-CCP), and c) C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR)? ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing. **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation

18. Has the patient been diagnosed with active articular juvenile idiopathic arthritis? **Y** ☐ **N** ☐

19. Is the patient 2 years of age or older? **Y** ☐ **N** ☐

20. Is the requested drug being prescribed by or in consultation with a rheumatologist? **Y** ☐ **N** ☐

21. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug? **Y** ☐ **N** ☐

22. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

- ☐ Yes (If checked, go to 25)
- ☐ No (If checked, go to 23)
- ☐ Unknown (If checked, go to 25)

23. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug or a biosimilar of the requested drug? **Y** ☐ **N** ☐

24. Which of the following has the patient experienced an improvement in from baseline? ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response.

- ☐ Number of joints with active arthritis (e.g., swelling, pain, limitation of motion) (If checked, go to 96)
- ☐ Number of joints with limitation of movement (If checked, go to 96)
- ☐ Functional ability (If checked, go to 96)
- ☐ None of the above (If checked, no further questions)

ACTION REQUIRED: Submit supporting documentation

25. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Xeljanz) indicated for the treatment of active articular juvenile idiopathic arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried. **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation

26. Has the patient had an inadequate response to methotrexate or another conventional synthetic drug (e.g., leflunomide, sulfasalazine, hydroxychloroquine) administered at an adequate dose and duration? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation

27. Has the patient had an inadequate response to a trial of scheduled non-steroidal anti-inflammatory drugs (NSAIDs) and/or intra-articular glucocorticoids (e.g., triamcinolone hexacetonide)? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation

28. Does the patient have one of the following risk factors for poor outcome: a) involvement of ankle, wrist, hip, sacroiliac joint, and/or temporomandibular joint (TMJ), b) presence of erosive disease or enthesitis, c) delay in diagnosis, d) elevated levels of inflammation markers, or e) symmetric disease? **Y** ☐ **N** ☐

29. Does the patient have any of the following risk factors for disease severity and potentially a more refractory disease course: a) positive rheumatoid factor, b) positive anti-cyclic citrullinated peptide antibodies, or c) pre-existing joint damage? **Y** ☐ **N** ☐

30. Does the patient meet any of the following: a) high-risk joints are involved (e.g., cervical spine, wrist, or hip), b) high disease activity, or c) high risk for disabling joint disease? **Y** ☐ **N** ☐

31. Is the patient 2 years of age or older? **Y** ☐ **N** ☐

32. Is the requested drug being prescribed by or in consultation with a rheumatologist? **Y** ☐ **N** ☐

33. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug? **Y** ☐ **N** ☐

34. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

- ☐ Yes (If checked, go to 37)
- ☐ No (If checked, go to 35)
- ☐ Unknown (If checked, go to 37)

35. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug or a biosimilar of the requested drug? **Y** ☐ **N** ☐

36. Which of the following has the patient experienced an improvement in from baseline? ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response.

- Number of joints with active arthritis (e.g., swelling, pain, limitation of motion) (If checked, go to 96) ☐
- Number of joints with limitation of movement (If checked, go to 96) ☐
- Functional ability (If checked, go to 96) ☐
- Systemic features (e.g., fevers, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly, or serositis) (If checked, go to 96) ☐
- None of the above (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

37. Has the patient been diagnosed with active systemic juvenile idiopathic arthritis (sJIA)? **Y** ☐ **N** ☐

38. Has the patient ever received or is currently receiving a biologic (e.g., Humira) indicated for the treatment of active systemic juvenile idiopathic arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried. **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation

39. Does the patient have active systemic features (e.g., fever, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly, serositis)? **Y** ☐ **N** ☐

40. Is the requested drug being prescribed by or in consultation with an oncologist or hematologist? **Y** ☐ **N** ☐

41. Is this a request for continuation of therapy with the requested drug or a biosimilar of the requested drug? **Y** ☐ **N** ☐

42. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

- Yes (If checked, go to 44) ☐
- No (If checked, go to 43) ☐
- Unknown (If checked, go to 44) ☐

43. Is there evidence of unacceptable toxicity or disease progression while on the current regimen? **Y** ☐ **N** ☐

44. Has the patient been tested for human immunodeficiency virus (HIV)? **Y** ☐ **N** ☐

45. What were the results of the HIV test?

- Positive (If checked, no further questions) ☐
- Negative (If checked, go to 46) ☐
- Unknown (If checked, no further questions) ☐

46. Has the patient been tested for herpesvirus-8? **Y** ☐ **N** ☐

47. What were the results of the herpesvirus-8 test?

- Positive (If checked, no further questions) ☐
- Negative (If checked, go to 48) ☐
- Unknown (If checked, no further questions) ☐

48. Has the disease progressed following treatment of relapsed or refractory disease? **Y** ☐ **N** ☐

49. Will the requested drug be used as a single agent? Y ☐ N ☐

50. Is the requested drug being prescribed by or in consultation with an oncologist or hematologist? Y ☐ N ☐

51. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug? Y ☐ N ☐

52. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

- Yes (If checked, go to 54) ☐
- No (If checked, go to 53) ☐
- Unknown (If checked, go to 54) ☐

53. Is there evidence of unacceptable toxicity or disease progression while on the current regimen? Y ☐ N ☐

54. Has the disease progressed following treatment of relapsed/refractory or progressive disease? Y ☐ N ☐

55. Will the requested drug be used as a single agent? Y ☐ N ☐

56. Is the requested drug being prescribed by or in consultation with an oncologist, hematologist, or rheumatologist? Y ☐ N ☐

57. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug? Y ☐ N ☐

58. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

- Yes (If checked, go to 60) ☐
- No (If checked, go to 59) ☐
- Unknown (If checked, go to 60) ☐

59. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug or a biosimilar of the requested drug? ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response. Y ☐ N ☐
   ACTION REQUIRED: Submit supporting documentation

60. Does the patient have severe immunotherapy-related inflammatory arthritis? Y ☐ N ☐

61. Has the patient had an inadequate response to corticosteroids or a conventional synthetic drug (e.g., methotrexate, sulfasalazine, leflunomide, hydroxychloroquine)? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. Y ☐ N ☐
   ACTION REQUIRED: Submit supporting documentation

62. Does the patient have an intolerance or contraindication to corticosteroids? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is if not advisable, please attach documentation of clinical reason to avoid therapy. Y ☐ N ☐
   ACTION REQUIRED: Submit supporting documentation

63. Does the patient have an intolerance or contraindication to a conventional synthetic drug (e.g., methotrexate, sulfasalazine, leflunomide, hydroxychloroquine)? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is if not advisable, please attach documentation of clinical reason to avoid therapy. Y ☐ N ☐
   ACTION REQUIRED: Submit supporting documentation

64. Is the patient an adult (18 years of age or older)? Y ☐ N ☐

65. Is the requested drug being prescribed by or in consultation with a rheumatologist? Y ☐ N ☐

66. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug? **Y** ☐ **N** ☐

67. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

- Yes (If checked, go to 70) ☐
- No (If checked, go to 68) ☐
- Unknown (If checked, go to 70) ☐

68. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug or a biosimilar of the requested drug? **Y** ☐ **N** ☐

69. Which of the following has the patient experienced an improvement in from baseline? ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response.

- Headaches (If checked, go to 96) ☐
- Scalp tenderness (If checked, go to 96) ☐
- Tenderness and/or thickening of superficial temporal arteries (If checked, go to 96) ☐
- Constitutional symptoms (e.g., weight loss, fever, fatigue, night sweats) (If checked, go to 96) ☐
- Jaw and/or tongue claudication (If checked, go to 96) ☐
- Acute visual symptoms (e.g., amaurosis fugax, acute visual loss, diplopia) (If checked, go to 96) ☐
- Symptoms of polymyalgia rheumatica (e.g., shoulder and/or hip girdle pain) (If checked, go to 96) ☐
- Limb claudication (If checked, go to 96) ☐
- None of the above (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

70. Has the diagnosis been confirmed by temporal artery biopsy or cross-sectional imaging? **Y** ☐ **N** ☐

71. Has the diagnosis been confirmed by acute-phase reactant elevation (i.e., high erythrocyte sedimentation rate [ESR] and/or high serum C-reactive protein [CRP])? **Y** ☐ **N** ☐

72. Is the requested drug being prescribed by or in consultation with an oncologist or hematologist? **Y** ☐ **N** ☐

73. Has the patient been diagnosed with chimeric antigen receptor (CAR) T cell-induced cytokine release syndrome (CRS)? **Y** ☐ **N** ☐

74. Is the patient 2 years of age or older? **Y** ☐ **N** ☐

75. Does the patient have refractory cytokine release syndrome (CRS) related to blinatumomab therapy? ACTION REQUIRED: If Yes, please also attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. **Y** ☐ **N** ☐

ACTION REQUIRED: Submit supporting documentation

76. What is the route of administration?

- Intravenous (If checked, no further questions) ☐
- Subcutaneous (If checked, no further questions) ☐

77. Is the requested drug being prescribed by or in consultation with an oncologist or hematologist? **Y** ☐ **N** ☐

78. Has the patient experienced an inadequate response to systemic corticosteroids? ACTION REQUIRED: If Yes, please also attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. **Y** ☐ **N** ☐

ACTION REQUIRED: Submit supporting documentation

79. Does the patient have an intolerance or contraindication to corticosteroids? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is if not advisable, please attach documentation of clinical reason to avoid therapy.
ACTION REQUIRED: Submit supporting documentation — Y ☐ N ☐

80. Is the patient an adult (18 years of age or older)? — Y ☐ N ☐

81. Is the requested drug being prescribed by or in consultation with a rheumatologist or pulmonologist? — Y ☐ N ☐

82. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug? — Y ☐ N ☐

83. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

- Yes (If checked, go to 84) ☐
- No (If checked, go to 96) ☐
- Unknown (If checked, go to 84) ☐

84. Has the diagnosis been confirmed by a high-resolution computed tomography (HRCT) study of the chest? ACTION REQUIRED: If Yes, please attach the radiology report.
ACTION REQUIRED: Submit supporting documentation — Y ☐ N ☐

85. Is the requested drug being prescribed by or in consultation with a rheumatologist? — Y ☐ N ☐

86. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug? — Y ☐ N ☐

87. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

- Yes (If checked, go to 90) ☐
- No (If checked, go to 88) ☐
- Unknown (If checked, go to 90) ☐

88. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug or a biosimilar of the requested drug? — Y ☐ N ☐

89. Which of the following has the patient experienced an improvement in from baseline? ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response.

- Morning stiffness (If checked, go to 96) ☐
- Hip or shoulder pain (If checked, go to 96) ☐
- Hip or shoulder range of motion (If checked, go to 96) ☐
- C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR) (If checked, go to 96) ☐
- None of the above (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

90. Has the patient experienced an inadequate response to systemic corticosteroids? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
ACTION REQUIRED: Submit supporting documentation — Y ☐ N ☐

91. Has the patient experienced a disease flare during a taper with systemic corticosteroids? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
ACTION REQUIRED: Submit supporting documentation — Y ☐ N ☐

92. Has the patient experienced an inadequate response to methotrexate? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
ACTION REQUIRED: Submit supporting documentation — Y ☐ N ☐

93. Does the patient have an intolerance or contraindication to systemic corticosteroids? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. If therapy is not advisable, please attach documentation of clinical reason to avoid therapy.
ACTION REQUIRED: Submit supporting documentation
Y ☐ N ☐

94. Does the patient have an intolerance or contraindication to methotrexate? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. If therapy is not advisable, please attach documentation of clinical reason to avoid therapy.
ACTION REQUIRED: Submit supporting documentation
Y ☐ N ☐

95. Please indicate the contraindication to methotrexate.

- Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease (If checked, go to 96) ☐
- Drug interaction (If checked, go to 96) ☐
- Risk of treatment-related toxicity (If checked, go to 96) ☐
- Pregnancy or currently planning pregnancy (If checked, go to 96) ☐
- Breastfeeding (If checked, go to 96) ☐
- Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension) (If checked, go to 96) ☐
- Hypersensitivity (If checked, go to 96) ☐
- History of intolerance or adverse event (If checked, go to 96) ☐
- Other, please specify. (If checked, no further questions) ☐

_____

96. What is the diagnosis?

- Rheumatoid arthritis (If checked, go to 97) ☐
- Polyarticular juvenile idiopathic arthritis (pJIA) (If checked, go to 105) ☐
- Oligoarticular juvenile idiopathic arthritis (If checked, go to 105) ☐
- Systemic juvenile idiopathic arthritis (sJIA) (If checked, go to 113) ☐
- Giant cell arteritis (If checked, go to 135) ☐
- Systemic sclerosis-associated interstitial lung disease (SSc-ILD) (If checked, go to 143) ☐
- Unicentric Castleman disease (If checked, go to 121) ☐
- Multicentric Castleman disease (If checked, go to 121) ☐
- Acute graft versus host disease (If checked, go to 121) ☐
- Immune checkpoint inhibitor-related inflammatory arthritis (If checked, go to 126) ☐
- Polymyalgia rheumatica (If checked, go to 126) ☐

97. What is the requested product?

- Actemra or Tyenne (If checked, go to 98) ☐
- Tofidence (IV only) (If checked, go to 99) ☐

98. What is the route of administration?

- Intravenous (If checked, go to 99) ☐
- Subcutaneous (If checked, go to 102) ☐

99. Does the prescribed dose exceed 8 mg per kg? Y ☐ N ☐

100. Is the prescribed frequency more frequent than one dose every 4 weeks? Y ☐ N ☐

101. What is the requested product?
- Actemra (If checked, no further questions) ☐
- Tofidence (If checked, no further questions) ☐
- Tyenne (If checked, no further questions) ☐

102. Does the prescribed dose exceed 162 mg? **Y** ☐ **N** ☐

103. Is the prescribed frequency more frequent than one dose every week? **Y** ☐ **N** ☐

104. What is the requested product?
- Actemra (If checked, no further questions) ☐
- Tyenne (If checked, no further questions) ☐

105. What is the requested product?
- Actemra or Tyenne (If checked, go to 106) ☐
- Tofidence (IV only) (If checked, go to 107) ☐

106. What is the route of administration?
- Intravenous (If checked, go to 107) ☐
- Subcutaneous (If checked, go to 110) ☐

107. Does the prescribed dose exceed 10 mg per kg? **Y** ☐ **N** ☐

108. Is the prescribed frequency more frequent than one dose every 4 weeks? **Y** ☐ **N** ☐

109. What is the requested product?
- Actemra (If checked, no further questions) ☐
- Tofidence (If checked, no further questions) ☐
- Tyenne (If checked, no further questions) ☐

110. Does the prescribed dose exceed 162 mg? **Y** ☐ **N** ☐

111. Is the prescribed frequency more frequent than one dose every 2 weeks? **Y** ☐ **N** ☐

112. What is the requested product?
- Actemra (If checked, no further questions) ☐
- Tyenne (If checked, no further questions) ☐

113. What is the requested product?
- Actemra or Tyenne (If checked, go to 114) ☐
- Tofidence (IV only) (If checked, go to 115) ☐

114. What is the route of administration?
- Intravenous (If checked, go to 115) ☐
- Subcutaneous (If checked, go to 118) ☐

115. Does the prescribed dose exceed 12 mg per kg? **Y** ☐ **N** ☐

116. Is the prescribed frequency more frequent than one dose every 2 weeks? **Y** ☐ **N** ☐

117. What is the requested product?

- Actemra (If checked, no further questions) ☐
- Tofidence (If checked, no further questions) ☐
- Tyenne (If checked, no further questions) ☐

118. Does the prescribed dose exceed 162 mg? **Y** ☐ **N** ☐

119. Is the prescribed frequency more frequent than one dose every week? **Y** ☐ **N** ☐

120. What is the requested product?

- Actemra (If checked, no further questions) ☐
- Tyenne (If checked, no further questions) ☐

121. Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)? **Y** ☐ **N** ☐

122. What is the route of administration?

- Intravenous (If checked, go to 123) ☐
- Subcutaneous (If checked, no further questions) ☐

123. Does the prescribed dose exceed 8 mg per kg? **Y** ☐ **N** ☐

124. Is the prescribed frequency more frequent than one dose every 2 weeks? **Y** ☐ **N** ☐

125. What is the requested product?

- Actemra (If checked, no further questions) ☐
- Tofidence (If checked, no further questions) ☐
- Tyenne (If checked, no further questions) ☐

126. Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)? **Y** ☐ **N** ☐

127. What is the requested product?

- Actemra or Tyenne (If checked, go to 128) ☐
- Tofidence (IV only) (If checked, go to 132) ☐

128. What is the route of administration?

- Intravenous (If checked, go to 132) ☐
- Subcutaneous (If checked, go to 129) ☐

129. Does the prescribed dose exceed 162 mg? **Y** ☐ **N** ☐

130. Is the prescribed frequency more frequent than one dose every week? **Y** ☐ **N** ☐

131. What is the requested product?

- Actemra (If checked, no further questions) ☐
- Tyenne (If checked, no further questions) ☐

132. Does the prescribed dose exceed 8 mg per kg? **Y** ☐ **N** ☐

133. Is the prescribed frequency more frequent than one dose every 4 weeks? **Y** ☐ **N** ☐

134. What is the requested product?

- Actemra (If checked, no further questions) ☐
- Tofidence (If checked, no further questions) ☐
- Tyenne (If checked, no further questions) ☐

135. What is the requested product?

- Actemra or Tyenne (If checked, go to 136) ☐
- Tofidence (IV only) (If checked, go to 137) ☐

136. What is the route of administration?

- Intravenous (If checked, go to 137) ☐
- Subcutaneous (If checked, go to 140) ☐

137. Does the prescribed dose exceed 6 mg per kg? **Y** ☐ **N** ☐

138. Is the prescribed frequency more frequent than one dose every 4 weeks? **Y** ☐ **N** ☐

139. What is the requested product?

- Actemra (If checked, no further questions) ☐
- Tofidence (If checked, no further questions) ☐
- Tyenne (If checked, no further questions) ☐

140. Does the prescribed dose exceed 162 mg? **Y** ☐ **N** ☐

141. Is the prescribed frequency more frequent than one dose every week? **Y** ☐ **N** ☐

142. What is the requested product?

- Actemra (If checked, no further questions) ☐
- Tyenne (If checked, no further questions) ☐

143. What is the requested product?

- Actemra or Tyenne (If checked, go to 144) ☐
- Tofidence (If checked, no further questions) ☐

144. What is the route of administration?

- Intravenous (If checked, no further questions) ☐
- Subcutaneous (If checked, go to 145) ☐

145. Does the prescribed dose exceed 162 mg? **Y** ☐ **N** ☐

146. Is the prescribed frequency more frequent than one dose every week? **Y** ☐ **N** ☐

147. What is the requested product?

- Actemra (If checked, no further questions) ☐
- Tyenne (If checked, no further questions) ☐

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

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