Prescriber Criteria Form

Tyenne 2026 PA Fax 6436-A v2 010126.docx
Tyenne (tocilizumab-aazg)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Tyenne (tocilizumab-aazg).

Drug Name:
Tyenne (tocilizumab-aazg)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Has the patient previously received the requested drug for rheumatoid arthritis? [If yes, then no further questions.]	Yes	No
2	Does the patient have a diagnosis of moderately to severely active rheumatoid arthritis? [If no, then skip to question 4.]	Yes	No
3	Does the patient meet either of the following criteria: A) Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to methotrexate (MTX), B) Patient experienced an inadequate treatment response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD)? [No further questions.]	Yes	No
4	Does the patient have any of the following diagnoses: A) active systemic juvenile idiopathic arthritis, B) giant cell arteritis, C) active polyarticular juvenile idiopathic arthritis? [If yes, then no further questions.]	Yes	No
5	Does the patient have Castleman's disease? [If yes, then no further questions.]	Yes	No
6	Does the patient have a diagnosis of sclerosis-associated interstitial lung disease (SSc-ILD)? [If no, then no further questions.]	Yes	No

7	Was the diagnosis confirmed by a high-resolution computer tomography (HRCT) study of the chest?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____