# Actemra, Tofidence, Tyenne

## HMSAMCD - Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-237-5512**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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**Patient's Name:** _____ **Date**: _____
**Patient's ID:** _____ **Patient's Date of Birth:** _____
**Patient's Phone Number:** _____
**Physician's Name:** _____
**Specialty:** _____ **NPI#:** _____
**Physician Office Telephone:** _____ **Physician Office Fax:** _____

***Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.***

**Additional Demographic Information:**

*Patient Weight:* _____*kg*

*Patient Height:* _____*ft* _____*inches*

**Indicate where the drug is being dispensed:**

❑ Office ❑ Outpatient Hospital ❑ Ambulatory Surgical ❑ Inpatient Hospital
❑ Off Campus Outpatient Hospital ❑ Urgent Care ❑ Emergency Room ❑ Birthing Center
❑ Military Facility ❑ Skilled Nursing Facility ❑ Nursing Facility ❑ Hospice
❑ Inpatient Psychiatric ❑ Psychiatric Residential Treatment ❑ End Stage Renal Facility
❑ Psychiatric Facility ❑ Pharmacy ❑ Other

**Indicate where the drug is being administered:**

❑ Ambulatory surgical ❑ Home ❑ Inpatient Hospital
❑ Office ❑ Outpatient Hospital ❑ Pharmacy

What is the ICD-10 code? _____

What product is being requested? ❒ Actemra ❒ Tofidence ❒ Tyenne

**Criteria Questions:**

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)?

❒ Yes, *Continue to #2*

❒ No, *Continue to #2*

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)?

❒ Yes, *Continue to #9*

❒ No, *Continue to #3*

3. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [TST], interferon-release assay [IGRA]) within 12 months of initiating therapy?

❒ Yes, *Continue to #4*

❒ No, *Continue to #4*

4. What were the results of the tuberculosis (TB) test?

❒ Positive for TB, *Continue to #5*

❒ Negative for TB, *Continue to #9*

❒ Unknown

5. Which of the following applies to the patient?

❒ Patient has latent TB and treatment for latent TB has been initiated, *Continue to #9*

❒ Patient has latent TB and treatment for latent TB has been completed, *Continue to #9*

❒ Patient has latent TB and treatment for latent TB has not been initiated, *Continue to #9*

❒ Patient has active TB, *Continue to #9*

*Indication*

9. What is the diagnosis?

❒ Rheumatoid arthritis, *Continue to #100*

❒ Polyarticular juvenile idiopathic arthritis (pJIA), *Continue to #200*

❒ Oligoarticular juvenile idiopathic arthritis, *Continue to #200*

❒ Systemic juvenile idiopathic arthritis (sJIA), *Continue to #300*

❒ Giant cell arteritis, *Continue to #500*

❒ Systemic sclerosis-associated interstitial lung disease (SSc-ILD), *Continue to #650*

❒ Unicentric Castleman disease, *Continue to #375*

❒ Multicentric Castleman disease, *Continue to #400*

❒ Immune checkpoint inhibitor-related toxicity, *Continue to #425*

❒ Immune checkpoint inhibitor-related inflammatory arthritis, *Continue to #428*

❒ Cytokine release syndrome, *Continue to #600*

❒ Acute graft versus host disease, *Continue to #625*

❒ Polymyalgia rheumatica, *Continue to #675*

❒ Other, *No Further Questions*

*Rheumatoid Arthritis*

100. Has the patient been diagnosed with moderately to severely active rheumatoid arthritis (RA)?

❒ Yes, *Continue to #101*

❒ No, *Continue to #101*

101. Is the patient an adult?

❒ Yes, *Continue to #102*

❒ No, *Continue to #102*

102. Is the requested drug being prescribed by or in consultation with a rheumatologist?

❒ Yes, *Continue to #103*

❒ No, *Continue to #103*

103. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?

❒ Yes, *Continue to #104*

❒ No, *Continue to #150*

*Continuation of Therapy*

104. 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, *Continue to #150*

❒ No, *Continue to #105*

❒ Unknown, *Continue to #150*

105. Has the patient achieved or maintained a positive clinical response since starting treatment with the requested drug or a biosimilar of the requested drug?

❒ Yes, *Continue to #106*

❒ No, *Continue to #107*

106. 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?

❒ Yes, *No Further Questions*

❒ No, *Continue to #107*

107. 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?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

*Initial Therapy*

*Prior treatment with another biologic or targeted synthetic drug*

150. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) indicated for moderately to severely active rheumatoid arthritis (excluding receiving the drug via samples or manufacturer's patient assistance program)?

❒ Yes, *No Further Questions*

❒ No, *Continue to #151*

*Biomarker testing and requirements regarding prior therapy*

151. 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?

❒ Yes, *No Further Questions*

❒ No, *Continue to #152*

152. 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)?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

*Articular Juvenile Idiopathic Arthritis*

200. Has the patient been diagnosed with active articular juvenile idiopathic arthritis?

❒ Yes, *Continue to #201*

❒ No, *Continue to #201*

201. Is the patient 2 years of age or older?

❒ Yes, *Continue to #202*

❒ No, *Continue to #202*

202. Is the requested drug being prescribed by or in consultation with a rheumatologist?

❒ Yes, *Continue to #203*

❒ No, *Continue to #203*

203. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?

❒ Yes, *Continue to #204*

❒ No, *Continue to #207*

*Continuation of Therapy*

204. 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, *Continue to #207*

❒ No, *Continue to #205*

❒ Unknown, *Continue to #207*

205. 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?

❒ Yes, *Continue to #206*

❒ No, *Continue to #206*

206. Which of the following has the patient experienced an improvement in from baseline?

❒ Number of joints with active arthritis (e.g., swelling, pain, limitation of motion), *No Further Questions*

❒ Number of joints with limitation of movement, *No Further Questions*

❒ Functional ability, *No Further Questions*

❒ None of the above, *No Further Questions*

*Initial Therapy*

*Prior treatment with another biologic or targeted synthetic drug*

207. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Xeljanz) indicated for active articular juvenile idiopathic arthritis (excluding receiving the drug via samples or a manufacturer's assistance program)?

❒ Yes, *No Further Questions*

❒ No, *Continue to #208*

*New starts*

208. Has the patient had an inadequate response to methotrexate or another conventional systemic drug (e.g., leflunomide, sulfasalazine, hydroxychloroquine) administered at an adequate dose and duration?

❒ Yes, *No Further Questions*

❒ No, *Continue to #209*

209. 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)?

❒ Yes, *Continue to #210*

❒ No, *Continue to #211*

210. 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?

❒ Yes, *No Further Questions*

❒ No, *Continue to #211*

211. 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?

❒ Yes, *Continue to #212*

❒ No, *Continue to #212*

212. 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?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

*Systemic Juvenile Idiopathic Arthritis*

300. Is the patient 2 years of age or older

❒ Yes, *Continue to #301*

❒ No, *Continue to #301*

301. Is the requested drug being prescribed by or in consultation with a rheumatologist?

❒ Yes, *Continue to #302*

❒ No, *Continue to #302*

302. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?

❒ Yes, *Continue to #303*

❒ No, *Continue to #306*

*Continuation of Therapy*

303. 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, *Continue to #306*

❒ No, *Continue to #304*

❒ Unknown, *Continue to #306*

304. 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?

❒ Yes, *Continue to #305*

❒ No, *Continue to #305*

305. Which of the following has the patient experienced an improvement in from baseline?

❒ Number of joints with active arthritis (e.g., swelling, pain, limitation of motion), *No Further Questions*

❒ Number of joints with limitation of movement, *No Further Questions*

❒ Functional ability, *No Further Questions*

❒ Systemic features (e.g., fevers, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly, or serositis), *No Further Questions*

❒ None of the above, *No Further Questions*

*Initial Therapy*

*Prior treatment with another biologic medication*

306. Has the patient been diagnosed with active systemic juvenile idiopathic arthritis (sJIA)?

❒ Yes, *Continue to #307*

❒ No, *Continue to #307*

307. Has the patient ever received or is currently receiving a biologic (e.g., Humira) indicated for active systemic juvenile idiopathic arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)?

❒ Yes, *No Further Questions*

❒ No, *Continue to #308*

*Requirements regarding prior therapy*

308. Does the patient have active systemic features (e.g., fever, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly, serositis)?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

*Unicentric Castleman's disease*

*Continuation of Therapy*

375. Is the requested drug being prescribed by or in consultation with an oncologist or hematologist?

❒ Yes, *Continue to #376*

❒ No, *Continue to #376*

376. Is this a request for continuation of therapy with the requested drug or a biosimilar of the requested drug?

❒ Yes, *Continue to #377*

❒ No, *Continue to #379*

377. 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, *Continue to #379*

❒ No, *Continue to #378*

❒ Unknown, *Continue to #379*

378. Is there evidence of unacceptable toxicity or disease progression on the current regimen?

❒ Yes, *Continue to #385*

❒ No, *Continue to #385*

*Initial Therapy*

379. Has the patient been tested for human immunodeficiency virus (HIV)?

❒ Yes, *Continue to #380*

❒ No, *Continue to #380*

380. What were the results of the HIV test?

❒ Positive, *Continue to #381*

❒ Negative, *Continue to #381*

❒ Unknown, *Continue to #381*

381. Has the patient been tested for herpesvirus-8?

❒ Yes, *Continue to #382*

❒ No, *Continue to #382*

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

❒ Positive, *Continue to #383*

❒ Negative, *Continue to #383*

❒ Unknown, *Continue to #383*

383. Has the disease progressed following treatment of relapsed or refractory disease or is the disease surgically unresectable?

❒ Yes, *Continue to #384*

❒ No, *Continue to #384*

384. Will the requested drug be used as a single agent?

❒ Yes, *Continue to #385*

❒ No, *Continue to #385*

385. What is the route of administration?

❒ Intravenous, *No Further Questions*

❒ Subcutaneous, *No Further Questions*

*Multicentric Castleman's disease*

*Continuation of Therapy*

400. Is the requested drug being prescribed by or in consultation with an oncologist or hematologist?

❒ Yes, *Continue to #401*

❒ No, *Continue to #401*

401. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?

❒ Yes, *Continue to #402*

❒ No, *Continue to #404*

402. 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, *Continue to #404*

❒ No, *Continue to #403*

❒ Unknown, *Continue to #404*

403. Is there evidence of unacceptable toxicity or disease progression on the current regimen?

❒ Yes, *Continue to #407*

❒ No, *Continue to #407*

*Initial Therapy*

404. Is the requested drug being used as a substitute for siltuximab when there is a shortage of siltuximab or it is not available?

❒ Yes, *Continue to #407*

❒ No, *Continue to #405*

405. Has the disease progressed following treatment of relapsed/refractory or progressive disease?

❒ Yes, *Continue to #406*

❒ No, *Continue to #406*

406. Will the requested drug be used as a single agent?

❒ Yes, *Continue to #407*

❒ No, *Continue to #407*

407. What is the route of administration?

❒ Intravenous, *No Further Questions*

❒ Subcutaneous, *No Further Questions*

*Immunotherapy-related toxicity*

425. Is the requested drug being prescribed by or in consultation with an oncologist or hematologist?

❒ Yes, *Continue to #426*

❒ No, *Continue to #426*

426. Has the patient had an inadequate response or intolerance to systemic corticosteroids?

❒ Yes, *No Further Questions*

❒ No, *Continue to #427*

427. Does the patient have a contraindication to corticosteroids?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

*Immunotherapy-related inflammatory arthritis*

428. Is the requested drug being prescribed by or in consultation with an oncologist, hematologist, or rheumatologist?

❒ Yes, *Continue to #429*

❒ No, *Continue to #429*

429. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?

❒ Yes, *Continue to #430*

❒ No, *Continue to #432*

430. 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, *Continue to #432*

❒ No, *Continue to #431*

❒ Unknown, *Continue to #432*

431. 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?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

*Initial Therapy*

432. Does the patient have moderate or severe immunotherapy-related inflammatory arthritis?

❒ Yes, *Continue to #433*

❒ No, *Continue to #433*

433. Has the patient had an inadequate response to corticosteroids or a conventional synthetic drug (e.g., methotrexate, sulfasalazine, leflunomide, hydroxychloroquine)?

❒ Yes, *No Further Questions*

❒ No, *Continue to #434*

434. Does the patient have an intolerance or contraindication to corticosteroids?

❒ Yes, *Continue to #435*

❒ No, *Continue to #435*

435. Does the patient have an intolerance or contraindication to a conventional synthetic drug (e.g., methotrexate, sulfasalazine, leflunomide, hydroxychloroquine)?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

*Giant Cell Arteritis*

*Continuation of Therapy*

500. Is the patient an adult?

❒ Yes, *Continue to #501*

❒ No, *Continue to #501*

501. Is the requested drug being prescribed by or in consultation with a rheumatologist?

❒ Yes, *Continue to #502*

❒ No, *Continue to #502*

502. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?

❒ Yes, *Continue to #503*

❒ No, *Continue to #506*

503. 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, *Continue to #506*

❒ No, *Continue to #504*

❒ Unknown, *Continue to #506*

504. 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?

❒ Yes, *Continue to #505*

❒ No, *Continue to #505*

505. Which of the following has the patient experienced an improvement in from baseline?

❒ Headaches, *No Further Questions*

❒ Scalp tenderness, *No Further Questions*

❒ Tenderness and/or thickening of superficial temporal arteries, *No Further Questions*

❒ Constitutional symptoms (e.g., weight loss, fever, fatigue, night sweats), *No Further Questions*

❒ Jaw and/or tongue claudication, *No Further Questions*

❒ Acute visual symptoms (e.g., amaurosis fugax, acute visual loss, diplopia), *No Further Questions*

❒ Symptoms of polymyalgia rheumatica (e.g., shoulder and/or hip girdle pain), *No Further Questions*

❒ Limb claudication, *No Further Questions*

❒ None of the above, *No Further Questions*

*Initial Therapy*

506. Has the diagnosis been confirmed by temporal artery biopsy or cross-sectional imaging?

❒ Yes, *No Further Questions*

❒ No, *Continue to #507*

507. 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])?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

*Cytokine Release Syndrome*

600. Is the requested drug being prescribed by or in consultation with an oncologist or hematologist?

❒ Yes, *Continue to #601*

❒ No, *Continue to #601*

601. Is the requested drug being prescribed for prophylaxis or treatment of cytokine release syndrome (CRS)?

❒ Yes, *Continue to #602*

❒ No, *Continue to #602*

602. What is the route of administration?

❒ Intravenous, *No Further Questions*

❒ Subcutaneous, *No Further Questions*

*Acute Graft versus Host Disease*

625. Is the requested drug being prescribed by or in consultation with an oncologist or hematologist?

❒ Yes, *Continue to #626*

❒ No, *Continue to #626*

626. Has the patient experienced an inadequate response to systemic corticosteroids?

❒ Yes, *Continue to #628*

❒ No, *Continue to #627*

627. Does the patient have an intolerance or contraindication to corticosteroids?

❒ Yes, *Continue to #628*

❒ No, *Continue to #628*

628. What is the route of administration?

❒ Intravenous, *No Further Questions*

❒ Subcutaneous, *No Further Questions*

*Systemic Sclerosis-Associated Interstitial Lung Disease*

650. Is the patient an adult?

❒ Yes, *Continue to #651*

❒ No, *Continue to #651*

651. Is the requested drug being prescribed by or in consultation with a rheumatologist or pulmonologist?

❒ Yes, *Continue to #652*

❒ No, *Continue to #652*

652. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?

❒ Yes, *Continue to #653*

❒ No, *Continue to #654*

653. 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, *Continue to #654*

❒ No, *No Further Questions*

❒ Unknown, *Continue to #654*

654. Has the diagnosis been confirmed by a high-resolution computed tomography (HRCT) study of the chest?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

*Polymyalgia rheumatica*

675. Is the requested drug being prescribed by or in consultation with a rheumatologist?

❒ Yes, *Continue to #676*

❒ No, *Continue to #676*

676. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?

❒ Yes, *Continue to #677*

❒ No, *Continue to #680*

677. 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, *Continue to #680*

❒ No, *Continue to #678*

❒ Unknown, *Continue to #680*

678. 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?

❒ Yes, *Continue to #679*

❒ No, *Continue to #679*

679. Which of the following has the patient experienced an improvement in from baseline?

❒ Morning stiffness, *No Further Questions*

❒ Hip or shoulder pain, *No Further Questions*

❒ Hip or shoulder range of motion, *No Further Questions*

❒ C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR), *No Further Questions*

❒ None of the above, *No Further Questions*

*Initial Therapy*

680. Has the patient had an inadequate response to systemic corticosteroids?

❒ Yes, *No Further Questions*

❒ No, *Continue to #681*

681. Has the patient had a disease flare during a taper with systemic corticosteroids?

❒ Yes, *No Further Questions*

❒ No, *Continue to #682*

682. Has the patient had an inadequate response to methotrexate?

❒ Yes, *No Further Questions*

❒ No, *Continue to #683*

683. Does the patient have an intolerance or contraindication to systemic corticosteroids?

❒ Yes, *Continue to #684*

❒ No, *Continue to #684*

684. Does the patient have an intolerance or contraindication to methotrexate?

❒ Yes, *Continue to #685*

❒ No, *Continue to #685*

685. Please indicate the contraindication to methotrexate

❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *No Further Questions*

❒ Drug interaction, *No Further Questions*

❒ Risk of treatment-related toxicity, *No Further Questions*

❒ Pregnancy or currently planning pregnancy, *No Further Questions*

❒ Breastfeeding, *No Further Questions*

❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *No Further Questions*

❒ Hypersensitivity, *No Further Questions*

❒ History of intolerance or adverse event, *No Further Questions*

❒ Other, *No Further Questions*

***I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.***

**X_____**

**Prescriber or Authorized Signature** **Date (mm/dd/yy)**