

**Cytokine and CAM – Interleukin-6 Agents
 Clinical Prior Authorization (PA) Request Form
 CT Medical Assistance Program
 To Be Completed By Prescriber**

<u>Prescriber Information</u>	<u>Patient Information</u>
Prescriber's NPI:	Patient's Medicaid ID Number:
Prescriber Name:	Patient Name:
Prescriber Subspecialty:	Patient DOB:
Phone ()	Patient Current Weight:
Fax ()	Patient Primary ICD Diagnosis Code:
<u>Prescription Information</u>	
Drug, Strength, and Dosage Form Requested:	Frequency of Dosing:
<input type="checkbox"/> New therapy <input type="checkbox"/> Continuation	Quantity Requested:

<u>Preferred Agents:</u>	<u>Non-Preferred Interleukin-6 Agents:</u>
TYENNE AUTOINJECT, SYRINGE* TYENNE VIAL*	ACTEMRA PEN, VIAL* AVTOZMA VIAL* ENSPRYNG SYRINGE KEVZARA PEN, SYRINGE TOFIDENCE VIAL*

*Tocilizumab or tocilizumab biosimilar

Clinical Information

(attach supporting documentation, **required**)

Note: Using samples to initiate therapy does not meet authorization requirements

1. Prescribed by or in consultation with a rheumatologist, neurologist, ophthalmologist, pulmonologist or any other specialist familiar with the treated disease state (or as appropriate for diagnosis)? ○ Please specify subspecialty: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is patient using in combination with another targeted immunomodulator? ○ Please specify alternate agent: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Does patient have an active TB, Hepatitis B or other active infection prior to initiation?	<input type="checkbox"/> Yes <input type="checkbox"/> No

<p>4. For diagnosis of Moderate-to-Severe disease activity of the following: Active Polyarticular Juvenile Idiopathic Arthritis (PJIA), Active System Juvenile Idiopathic Arthritis (SJIA), Giant Cell Arteritis (GCA) or Rheumatoid Arthritis (RA): Patient has trialed and failed the preferred agent TYENNE (tocilizumab-aazg) for a minimum of 30 days of therapy OR documented adverse drug event or adverse drug reaction (ADE/ADR) to TYENNE (tocilizumab-aazg)</p> <ul style="list-style-type: none"> ▪ TYENNE Trial Dates: _____ ▪ Reason for Contraindication or Failure: _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<p>5. For diagnosis of Polymyalgia Rheumatica (PMR): Patient has trialed and failed corticosteroids for a minimum of 30 days AND cannot tolerate corticosteroid taper OR contraindication to corticosteroids or documented adverse drug event or adverse drug reaction (ADE/ADR) to corticosteroids</p> <ul style="list-style-type: none"> ▪ CORTICOSTEROID agent trialed: _____ ▪ Trial Dates: _____ ▪ Reason for Contraindication or Failure: _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

For Initial Approval:
Medication Requested and Documented diagnosis of ONE of the following:
(attach supporting documentation, required)

<p><u>Actemra (tocilizumab):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Cytokine Release Syndrome (CRS) (2+ years of age) AND a medical reason the preferred agent TYENNE cannot be used: _____ <hr/> <p>OR</p> <ul style="list-style-type: none"> • ONE of the following: <ul style="list-style-type: none"> ▪ Active Polyarticular Juvenile Idiopathic Arthritis (PJIA) (2+ years of age) OR ▪ Active System Juvenile Idiopathic Arthritis (SJIA) (2+ years of age) OR ▪ Giant Cell Arteritis (GCA) (18+ years of age) OR ▪ Moderate to Severe Rheumatoid Arthritis (RA) (18+ years of age) OR ▪ Systemic Sclerosis-associated Interstitial Lung Disease (SSc-ILD) (18+ years of age) AND <ul style="list-style-type: none"> ○ Failure to achieve the desired therapeutic outcome following a trial of at least ONE preferred 	<input type="checkbox"/> Yes <input type="checkbox"/> No
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<p>agent appropriate for the specified indication (as outlined above in Questions 4 of the Clinical Information section)</p>	
<p><u>Avtozma (tocilizumab-anoh):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Cytokine Release Syndrome (CRS) (2+ years of age) AND a medical reason the preferred agent TYENNE cannot be used: _____ _____ <p>OR</p> <ul style="list-style-type: none"> • ONE of the following: <ul style="list-style-type: none"> ▪ Active Polyarticular Juvenile Idiopathic Arthritis (PJIA) (2+ years of age) OR ▪ Active System Juvenile Idiopathic Arthritis (SJIA) (2+ years of age) OR ▪ Giant Cell Arteritis (GCA) (18+ years of age) OR ▪ Moderate to Severe Rheumatoid Arthritis (RA) (18+ years of age) <p>AND</p> <ul style="list-style-type: none"> ○ Failure to achieve the desired therapeutic outcome following a trial of at least ONE preferred agent appropriate for the specified indication (as outlined above in Questions 4 of the Clinical Information section) 	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><u>Enspryng (satralizumab-mwge):</u></p> <ul style="list-style-type: none"> • Patient (18+ years old) has a documented diagnosis of Neuro-myelitis Optica Spectrum Disorder NMOSD with submitted documentation of positive lab results for anti-aquaporin-4 (AQP4) antibody 	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><u>Kevzara (sarilumab):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of ONE of the following: <ul style="list-style-type: none"> ○ Active Polyarticular Juvenile Idiopathic Arthritis (PJIA) in patients who weigh 63kg or greater OR ○ Moderate to Severe Rheumatoid Arthritis (RA) (18+ years old) OR ○ Polymyalgia Rheumatica (PMR) (18+ years old) AND • Failure to achieve the desired therapeutic outcome following a trial of at least ONE preferred agent appropriate for the specified indication (as outlined above in Questions 4 and 5 of the Clinical Information section) 	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><u>Tofidence (tocilizumab-bavi):</u></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

<ul style="list-style-type: none"> • Patient has a documented diagnosis of ONE of the following: <ul style="list-style-type: none"> ○ Active System Juvenile Idiopathic Arthritis (SJIA) (2+ years old) OR ○ Giant Cell Arteritis (GCA) (18+ years old) OR ○ Moderate to Severe Rheumatoid Arthritis (RA) (18+ years old) OR ○ Active Polyarticular Juvenile Idiopathic Arthritis (PJIA) (2+ years old) AND • Failure to achieve the desired therapeutic outcome following a trial of at least ONE preferred agent appropriate for the specified indication (as outlined above in Question 4 of the Clinical Information section) 	
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Renewal Information

(attach supporting documentation, **required**)

Note: Using samples to initiate therapy does not meet renewal authorization requirements

<ul style="list-style-type: none"> • Has the patient previously met the required criteria set forth in Initial Approval Section above? <ul style="list-style-type: none"> ○ Previous Approved Prior Authorization Number: _____ ○ Approval Dates: _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> • Provider has completed the Clinical Information and Initial Approval sections above for ALL Non-Preferred Tocilizumab formulations <p><i>NOTE: Initial therapy requirements apply to both new starts and continued therapy requests for non-preferred tocilizumab formulations</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<ul style="list-style-type: none"> • Patients' clinical response to treatment and ongoing safety has been documented and monitored 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> • Prescriber attests that the patient has a continued need for therapy and is compliant with current regimen 	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please Note: Pharmacies should not be contacting prescribers to provide pre-signed PA forms or submitting pre-signed forms for PA, nor should prescribing providers be requesting that pharmacies perform PA activities for them. PA requests must originate from the prescriber, and only the prescriber should sign the form at the time of PA submission. I certify that documentation is maintained in my files and the information given is true and accurate for the medication requested, subject to penalty under section 17b-99 of the Connecticut General Statutes and sections 17-83k-1- to 17-83k-7, inclusive, of the Regulations of Connecticut State Agencies. I certify that the above-referenced member is a patient under my clinic's/practice's ongoing care. I understand that a prior authorization may not exceed one (1) year from the date of fill for non- controlled medications. Authorizations for Early Refill Requests are valid one time only.

Prescriber Signature*: _____ **Date:** _____

*** Mandatory (others may not sign for prescriber). In accordance with federal law, prescribers must be enrolled in the Connecticut Medical Assistance Program (CMAP). CMAP will not pay for prescriptions written by a non-enrolled provider.**

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