South Dakota Department of Social Services

Please note: All information below is required to process this request.
Fax to 1-844-403-1029.
Mon-Sat: 7am to 7pm Central

Tyenne^{TM} Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			**Provider Information** (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand** ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:
- ❑ Moderately to severely active rheumatoid arthritis (RA)
- ❑ Active polyarticular juvenile idiopathic arthritis (pJIA)
- ❑ Active systemic juvenile idiopathic arthritis (sJIA)
- ❑ Temporal arteritis or giant cell arteritis (GCA)
- ❑ Systemic sclerosis-associated interstitial lung disease
- ❑ Other diagnosis: ____________________ ICD-10 Code(s): ____________________

Clinical information:
Select if Actemra is prescribed by or in consultation with one of the following specialists:
❑ Allergist/Immunologist ❑ Rheumatologist ❑ Other ____________________
Will Tyenne be used in combination with another biologic agent or targeted immunomodulator? ❑ **Yes** ❑ **No**

For moderately to severely active rheumatoid arthritis (RA), also answer the following:
Has the patient had an inadequate response to, intolerance to, or contraindication to one or more non-biologic disease modifying anti-rheumatic drugs (DMARDs)? ❑ **Yes** ❑ **No** List ____________________

For active polyarticular juvenile idiopathic arthritis (pJIA), also answer the following:
Has the patient had an inadequate response to, intolerance to, or contraindication to one or more non-biologic disease modifying anti-rheumatic drugs (DMARDs)? ❑ **Yes** ❑ **No** List ____________________

For active systemic juvenile idiopathic arthritis (sJIA), also answer the following:
Has the patient had an inadequate response or intolerance to at least one oral systemic agent [i.e., non-steroidal anti-inflammatory drugs (NSAIDs), corticosteroid]? ❑ **Yes** ❑ **No** List ____________________

For temporal arteritis or giant cell arteritis (GCA), also answer the following:
Has the patient had an inadequate response to, intolerance to, or contraindication to oral or parenteral corticosteroid? ❑ **Yes** ❑ **No** List ____________________

Quantity limit requests:
What is the quantity requested per TREATMENT? ______ syringe every ______ weeks
What is the reason for exceeding the plan limitations?
- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: ____________________

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Please note: All information below is required to process this request.
Fax to 1-844-403-1029.
Mon-Sat: 7am to 7pm Central

Tyenne™ Prior Authorization Request Form (Page 2 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

___

___

___

___

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**