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August 17, 2026

UPDATED PRIOR AUTHORIZATION CRITERIA FOR TOCILIZUMAB (ACTEMRA) AND TOCILIZUMAB-AAZG (TYENNE)

Dear Provider,

Effective November 1, 2026, the criteria for tocilizumab (Actemra) and tocilizumab-aazg (Tyenne) will be updated to require use of preferred biosimilar(s). These products are on the non-Medicare list of office-administered drugs requiring prior authorization. This change does not affect current authorizations. However, any new authorizations are subject to the criteria below. **This letter serves as notification of the change in prior authorization criteria required for administering this medication under the medical benefit.**

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (Kaiser Permanente) require prior authorization for a select group of injectable drugs that may be administered under the medical benefit in a physician's office or by home infusion. These reviews are intended to ensure consistent benefit adjudication as well as appropriate utilization in accordance with the Kaiser Permanente Pharmacy & Therapeutics Committee's evidence-based criteria for coverage.

BRAND NAME	GENERIC NAME	HCPCS
Actemra	Tocilizumab	J3262
Tyenne	Tocilizumab-aazg	Q5135

Prior Authorization Criteria for tocilizumab (Actemra) and tocilizumab-aazg (Tyenne) (changes in bold):

DRUG NAME	COVERAGE CRITERIA

Tocilizumab (Actemra)	Covered for **patients ~~new starts~~** who have a failure, contraindication, or intolerance to tocilizumab-anoh (Avtozma) **and an additional tocilizumab biosimilar** AND one of the following:
	• Covered for adult patients ≥ 18 years old with thyroid eye disease (TED) who meet the following criteria:
	  ○ Confirmed diagnosis of active TED by an oculoplastic surgeon
	  ○ Clinical Activity Score (CAS) ≥4 (on the 7-item scale)
	  ○ Moderate-to-severe active TED (not sight-threatening but has appreciable impact on daily life), associated with at least one of the following:
	  ▪ Lid retraction ≥2 mm
	  ▪ Moderate or severe soft tissue involvement
	  ▪ Exophthalmos ≥3 mm above normal for race and gender
	  ▪ Intermittent or constant diplopia
	  ○ Inadequate response, intolerance, or contraindication to IV steroid therapy with or without radiation therapy
	• Covered for patients with neuromyelitis optica spectrum disorder (NMOSD) who meet the following criteria:
	  ○ Prescribed by or in consultation with a Multiple sclerosis specialist or Neurologist

DRUG NAME	COVERAGE CRITERIA
	○ Age ≥18 years ○ AQP4 antibody seropositive • Covered for patients with rheumatoid arthritis who meet the following criteria: ○ Age ≥ 18 years ○ Diagnosis of rheumatoid arthritis ○ Failed an adequate trial, or has an allergy, intolerance, or contraindication to the following: ○ csDMARD: Methotrexate ○ TNF Inhibitors (≥ 1 of the following): ▪ adalimumab (e.g., Amjevita) ▪ infliximab (e.g., Inflectra) • Covered for cytokine release syndrome due to chimeric antigen receptor-T (CAR-T) therapy. • Covered for patients with giant cell arteritis who meet the following criteria: ○ Age ≥ 18 years ○ Diagnosis of giant cell arteritis ○ Prescribed by or in consultation with a rheumatologist ○ Failed an adequate trial, or has an allergy, intolerance, or contraindication to the following: ▪ Glucocorticoids: Unable to taper glucocorticoid treatment without disease relapse • Covered for patients ≥ 2 years old with systemic subtype juvenile idiopathic arthritis who have failure, contraindication, or intolerance to NSAIDs, and glucocorticoids • Covered for patients ≥ 2 years old with polyarticular juvenile idiopathic arthritis (JIA) who have had failure, contraindication, or intolerance to methotrexate ~~**Established patients on Actemra must have a documented inadequate response or intolerance to tocilizumab biosimilars (e.g., Tyenne)**~~ Not covered for use in combination with disease modifying or other biologic therapies including (but not limited to): • infliximab, adalimumab, etanercept, vedolizumab, rituximab, abatacept, certolizumab, golimumab, ustekinumab, canakinumab, tofacitinib, upadacitinib, ozanimod, apremilast Not covered under the medical benefit for other indications (hospital, clinic, or home infusion) • Note: may be covered under the pharmacy benefit **Quantity Limit:** • TED and NMOSD: 800 mg every 4 weeks • Cytokine release syndrome associated with CAR-T: 800 mg up to 4 doses 8 hours apart • Polyarticular juvenile idiopathic arthritis: 800 mg every 4 weeks • Systemic subtype juvenile idiopathic arthritis: 800 mg every 2 weeks Note: Must be administered in a non-hospital setting. See site of care policy for criteria, reauthorization, and exceptions for new starts.

DRUG NAME	COVERAGE CRITERIA
	Members will have in-network benefit coverage for select home-infused medications and supplies only when they get these medicines and supplies through Kaiser Permanente Specialty Home Infusion. There is no out-of-network benefit coverage for home infusion. See Infused Drugs Restricted to Kaiser Permanente Washington's Specialty Pharmacy Network for medications impacted by this change.

Tocilizumab-aazg (Tyenne)	**Covered for patients who have a failure, contraindication, or intolerance to the preferred biosimilar tocilizumab-anoh (Avtozma) AND one of the following:**
	• Covered for adult patients ≥ 18 years old with thyroid eye disease (TED) who meet the following criteria:
	  ○ Confirmed diagnosis of active TED by an oculoplastic surgeon
	  ○ Clinical Activity Score (CAS) ≥4 (on the 7-item scale)
	  ○ Moderate-to-severe active TED (not sight-threatening but has appreciable impact on daily life), associated with at least one of the following:
	  ▪ Lid retraction ≥2 mm
	  ▪ Moderate or severe soft tissue involvement
	  ▪ Exophthalmos ≥3 mm above normal for race and gender
	  ▪ Intermittent or constant diplopia
	  ○ Inadequate response, intolerance, or contraindication to IV steroid therapy with or without radiation therapy
	• Covered for patients with neuromyelitis optica spectrum disorder (NMOSD) who meet the following criteria:
	  ○ Prescribed by or in consultation with a Multiple sclerosis specialist or Neurologist
	  ○ Age ≥18 years
	  ○ AQP4 antibody seropositive
	• Covered for patients with rheumatoid arthritis who meet the following criteria:
	  ○ Age ≥ 18 years
	  ○ Diagnosis of rheumatoid arthritis
	  ○ Failed an adequate trial, or has an allergy, intolerance, or contraindication to the following:
	  ○ csDMARD: Methotrexate
	  ○ TNF Inhibitors (≥ 1 of the following):
	  ▪ adalimumab (e.g., Amjevita)
	  ▪ infliximab (e.g., Inflectra)
	• Covered for cytokine release syndrome due to chimeric antigen receptor-T (CAR-T) therapy
	• Covered for patients with giant cell arteritis who meet the following criteria:
	  ○ Age ≥ 18 years
	  ○ Diagnosis of giant cell arteritis
	  ○ Prescribed by or in consultation with a rheumatologist
	  ○ Failed an adequate trial, or has an allergy, intolerance, or contraindication to the following:
	  ▪ Glucocorticoids: Unable to taper glucocorticoid treatment without disease relapse
	• Covered for patients ≥ 2 years old with systemic subtype juvenile idiopathic arthritis who have failure, contraindication, or intolerance to NSAIDs, and glucocorticoids

DRUG NAME	COVERAGE CRITERIA
	• Covered for patients ≥ 2 years old with polyarticular juvenile idiopathic arthritis (JIA) who have had failure, contraindication, or intolerance to methotrexate Not covered for use in combination with disease modifying or other biologic therapies including (but not limited to): • infliximab, adalimumab, etanercept, vedolizumab, rituximab, abatacept, certolizumab, golimumab, ustekinumab, canakinumab, tofacitinib, upadacitinib, ozanimod, apremilast Not covered under the medical benefit for other indications (hospital, clinic, or home infusion) • Note: may be covered under the pharmacy benefit **Quantity Limit:** • TED and NMOSD: 800 mg every 4 weeks • Cytokine release syndrome associated with CAR-T: 800 mg up to 4 doses 8 hours apart • Polyarticular juvenile idiopathic arthritis: 800 mg every 4 weeks • Systemic subtype juvenile idiopathic arthritis: 800 mg every 2 weeks Note: Must be administered in a non-hospital setting. See site of care policy for criteria, reauthorization, and exceptions for new starts Members will have in-network benefit coverage for select home-infused medications and supplies only when they get these medicines and supplies through Kaiser Permanente Specialty Home Infusion. There is no out-of-network benefit coverage for home infusion. See Infused Drugs Restricted to Kaiser Permanente Washington's Specialty Pharmacy Network for medications impacted by this change.

Additional Information
A complete list of office-administered injectable drugs requiring prior authorization can be found on the Kaiser Permanente provider website at https://wa-provider.kaiserpermanente.org/provider-manual/clinical-review/officeinject.

To request prior authorization review, please use the Referral Request online form (login required) located on the Kaiser Permanente provider website. You can also fax your request to the Review Services department toll-free at 1-888-282-2685.

Thank you for the care you provide for our members, your patients. If you have any questions about this process, please call Review Services at 1-800-289-1363, Monday through Friday, from 8:00 a.m. to 5:00 p.m.

Sincerely,

Ravi Ubriani, MD, Chair
Pharmacy & Therapeutics Committee