# PRIOR AUTHORIZATION REQUEST

## Kevzara

**Patient Information:**

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|---|---|
| Name: | |
| Member ID: | |
| Address: | |
| City, State, Zip: | |
| Date of Birth: | |

**Prescriber Information:**

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|---|---|
| Name: | |
| NPI: | |
| Phone Number: | |
| Fax Number | |
| Address: | |
| City, State, Zip: | |

**Requested Medication**

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|---|---|
| Rx Name: | |
| Rx Strength | |
| Rx Quantity: | |
| Rx Frequency: | |
| Rx Route of Administration: | |
| Diagnosis and ICD Code: | |

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

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| 1 | Is the patient currently using other biologic or targeted synthetic disease modifying antirheumatic drugs (DMARDS)?<br>[Note: Examples of biologics include adalimumab SC products (Humira, biosimilars), Cimzia, etanercept SC products (Enbrel, biosimilars), infliximab IV products (Remicade, biosimilars), Actemra (IV or SC), Simponi SC, Simponi Aria (IV), Orencia (IV or SC), rituximab IV products (Rituxan, biosimilars), Ilaris, Kineret, Stelara (SC or IV), Siliq, Cosentyx, Taltz, Ilumya, Skyrizi, Tremfya, Entyvio OR targeted synthetic DMARD (such as Otezla, Olumiant, Rinvoq, or Xeljanz/XR)]?<br>[If yes, no further questions.] | Yes | No |
| 2 | Is the patient currently receiving the requested medication? | Yes | No |

**If you have any questions, call: 1-888-258-8250**

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| | [If no, skip to question 11.] | | |
| 3 | Has the patient been receiving medication samples for the requested medication?<br>[If yes, skip to question 11.] | Yes | No |
| 4 | Does the patient have a previously approved prior authorization (PA) on file with the current plan?<br>[Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.]<br>[If no, skip to question 10.] | Yes | No |
| 5 | Has the patient been established on therapy for at least 3 months?<br>[If no, skip to question 11.] | Yes | No |
| 6 | What is the diagnosis or indication?<br>[] Rheumatoid arthritis (If checked, go to 9)<br>[] Ankylosing spondylitis (If checked, no further questions)<br>[] Polymyalgia rheumatica (If checked, go to 7)<br>[] Covid-19 (If checked, no further questions)<br>[] Other (If checked, no further questions) | | |
| 7 | When assessed by at least ONE objective measure, has the patient experienced a beneficial clinical response from baseline (prior to initiating Kevzara)?<br>[Note: Examples of objective measures are serum markers (such as: C-reactive protein, erythrocyte sedimentation rate), resolution of fever, and/or reduced dosage of corticosteroids.]<br>[If yes, no further questions.] | Yes | No |
| 8 | Compared with baseline (prior to initiating Kevzara), has the patient experienced an improvement in at least ONE symptom, such as decreased shoulder, neck, upper arm, hip, or thigh pain or stiffness; improved range of motion; and/or decreased fatigue? ACTION REQUIRED: Submit supporting documentation.<br>[No further questions.] | Yes | No |
| 9 | Has documentation been submitted to confirm that the patient has experienced a clinically significant response as determined by the provider?<br>[Note: Examples of a response to therapy include less joint pain, morning stiffness, or fatigue; improved function or activities of daily living; decreased soft tissue swelling in joints or tendon sheaths; improved laboratory values; reduced dosage of corticosteroids. The patient may not have a full response, but there should have been a recent or past response to Kevzara.]<br>[No further questions.] | Yes | No |
| 10 | Has documentation been submitted to confirm that the patient has experienced a | Yes | No |

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| | clinically significant response as determined by the provider? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.] | | |
| 11 | What is the diagnosis or indication?<br>[] Rheumatoid arthritis (If checked, go to 15)<br><br>[] Ankylosing spondylitis (If checked, no further questions)<br><br>[] Polymyalgia rheumatica (If checked, go to 12)<br><br>[] Covid-19 (If checked, no further questions)<br><br>[] Other (If checked, no further questions) | | |
| 12 | Does the patient have a documented diagnosis of polymyalgia rheumatica?<br>[If no, no further questions.] | Yes | No |
| 13 | Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or trial and failure of at least TWO systemic corticosteroids for at least 120 days? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.] | Yes | No |
| 14 | Does the patient continue to have symptoms despite corticosteroid tapering?<br>[Note: An example of a systemic corticosteroid is prednisone.]<br>[If yes, skip to question 20.]<br>[If no, no further questions.] | Yes | No |
| 15 | Has the patient tried ONE conventional synthetic disease-modifying antirheumatic drug (DMARD) for at least 3 months?<br>[Note: Examples of conventional synthetic DMARDs include methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine.]<br>[If yes, skip to question 17.] | Yes | No |
| 16 | Has documentation been submitted to confirm that the patient has an intolerance to at least TWO disease-modifying antirheumatic drugs (DMARDs)? ACTION REQUIRED: Submit supporting documentation.<br>[Note: Examples of conventional synthetic DMARDs include methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine.]<br>[If no, no further questions.] | Yes | No |
| 17 | Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or failed treatment for at least 3 months with preferred TNF inhibitors: Enbrel (etanercept) and an adalimumab product (Hadlima, Yusimry, or adalimumab- adbm)? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.] | Yes | No |
| 18 | Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or failed treatment for at least 3 months with preferred JAK | Yes | No |

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| | inhibitor: Xeljanz? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.] | | |
| 19 | Does the dose of the requested medication exceed Food and Drug Administration (FDA) approved labeled dosing for the indication rheumatoid arthritis? [If yes, no further questions.] | Yes | No |
| 20 | Is the requested medication being prescribed by, or in consultation with a rheumatologist? | Yes | No |

***Please document the diagnoses, symptoms, and/or any other information important to this review:***

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

**FAX COMPLETED FORM TO: 1-833-896-0656**

**Disclaimer:** An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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**If you have any questions, call: 1-888-258-8250**