PRIOR AUTHORIZATION REQUEST

KEVZARA

Patient Information:

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

Prescriber Information:

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

Requested Medication

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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is the patient currently using other biologic or targeted synthetic disease modifying antirheumatic drugs (DMARDs)? [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, or Entyvio OR targeted synthetic DMARDs (such as Otezla, Olumiant, Rinvoq, or	Yes	No

PRIOR AUTHORIZATION REQUEST

	Xeljanz/XR).]? [If yes, no further questions.]		
2	Is the request an INITIAL or CONTINUATION of therapy? [] Initial (If checked, go to 8) [] Continuation (If checked, go to 3)	Yes	No
3	Is the patient currently receiving the requested medication? [If no, skip to question 8.]	Yes	No
4	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 8.]	Yes	No
5	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [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.] [If no, skip to question 8.]	Yes	No
6	Has the patient been established on therapy for at least 3 months? [If no, skip to question 8.]	Yes	No
7	Has documentation been provided to confirm that the patient has had a clinically significant response to therapy, as determined by the prescriber? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
8	What is the diagnosis or indication? [] Polymyalgia rheumatica (If checked, go to 9) [] Rheumatoid arthritis (If checked, go to 14) [] Polyarticular Juvenile Idiopathic Arthritis (If checked, go to 20) [] Other (If checked, no further questions)		
9	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
10	Does the patient have a documented diagnosis of polymyalgia rheumatica? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
11	Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or trial and failure of at least TWO systemic corticosteroids? ACTION REQUIRED: Submit supporting documentation.	Yes	No

PRIOR AUTHORIZATION REQUEST

	[If no, no further questions.]		
12	Is the requested medication being prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
13	Does the prescribed dosing exceed Food and Drug Administration (FDA) approved indication? [Dosing: 200 mg subcutaneous every two weeks.] [If yes, no further questions.]	Yes	No
14	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
15	Has the patient tried TWO conventional synthetic disease-modifying antirheumatic drugs (DMARDs) for at least 3 months? [Note: Examples of conventional synthetic DMARDs include methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine.] [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 conventional synthetic disease-modifying antirheumatic drugs (DMARDs)? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of conventional synthetic DMARDs include methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine.] [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 tumor necrosis factor (TNF) inhibitor, an adalimumab product (Hadlima, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
18	Is the requested medication being prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
19	Does the prescribed dosing exceed Food and Drug Administration (FDA) approved indication? [Dosing: 200 mg subcutaneous every two weeks.] [No further questions.]	Yes	No
20	Does the patient weigh greater than or equal to 63 kg? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions]	Yes	No
21	Has the patient tried TWO conventional synthetic disease-modifying antirheumatic drugs (DMARDs) for at least 3 months? [Note: Examples of conventional synthetic DMARDs include methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine.]		

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PRIOR AUTHORIZATION REQUEST

	[If yes, skip to question 23.]		
22	Has documentation been submitted to confirm that the patient has an intolerance to at least TWO conventional synthetic disease-modifying antirheumatic drugs (DMARDs)? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of conventional synthetic DMARDs include methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine.] [If no, no further questions.]	Yes	No
23	Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or failed treatment for at least 3 months with preferred tumor necrosis factor (TNF) inhibitor, an adalimumab product (Hadlima, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
24	Is the requested medication being prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
25	Does the prescribed dosing exceed Food and Drug Administration (FDA) approved indication? [Dosing: 200 mg subcutaneous every two weeks.]	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.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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