

Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to:

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Medicare Part B

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Medicare Part D

This request is:

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Expedited request

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Standard request

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Kevzara[®] (sarilumab)

Member

Last Name: _____

First Name: _____

ID #: _____

DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____

Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____

Contact Name: _____

Provider Signature: _____

Date: _____

Drug information

☐ New request

☐ Continuation request

☐ Kevzara prefilled pen

☐ Kevzara prefilled syringe

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

For this drug to be covered, the patient must meet the following criteria:

1. Must be used for a medically accepted indication*
2. For rheumatoid arthritis, must first have a documented trial and failure (defined as an inability to improve symptoms) or intolerance to all the following:
 - a. One non-biologic immunomodulator (e.g. methotrexate, leflunomide, sulfasalazine, hydroxychloroquine)
 - b. Humira or Enbrel
3. Prescriber is a specialist or has consulted with a specialist for the condition being treated
4. Must not use Kevzara in combination with other biological drugs (e.g., Enbrel, Humira)

Medically accepted indication*

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — or — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and Lexi-Drugs.)

Additional information

Note: When criteria are met, coverage duration is 1 year

Priority Health Precertification Documentation

A. Is the prescriber a specialist or consulted with a specialist for the condition being treated?

☐ Yes

☐ No. **Are you requesting an exception to the criteria?**

☐ Yes. **Rationale for exception:** _____

☐ No

B. Will Kevzara be used in combination with other biological drugs (e.g., Humira, Enbrel)?

☐ No

☐ Yes. **Are you requesting an exception to the criteria?**

☐ Yes. **Rationale for exception:** _____

☐ No

C. Answer the applicable questions in the table below.

Condition	Additional requirements for specific indications
<i>(Please check the appropriate boxes to indicate the patient has met the required criteria)</i>	
<input type="checkbox"/> Rheumatoid arthritis	<p>1. Has the patient had a documented trial and failure (defined as an inability to improve symptoms) or intolerance to 1 non-biologic immunomodulator?</p> <p><input type="checkbox"/> Yes.</p> <p><input type="checkbox"/> No. Are you requesting an exception to the criteria?</p> <p><input type="checkbox"/> Yes. Rationale for exception: _____</p> <p><input type="checkbox"/> No</p> <p>2. Has the patient had a documented trial and failure (defined as an inability to improve symptoms) or intolerance to Humira or Enbrel?</p> <p><input type="checkbox"/> Yes.</p> <p><input type="checkbox"/> No. Are you requesting an exception to the criteria?</p> <p><input type="checkbox"/> Yes. Rationale for exception: _____</p> <p><input type="checkbox"/> No</p>
<input type="checkbox"/> Other condition	<p>1. The patient's condition is: _____</p> <p>2. Rationale for use is: _____</p>

Priority Health Medicare Exception Request (*exceptions to the above criteria*)

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No

If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Kevzara likely be the most effective option for this patient?

☐ Yes ☐ No

If yes, please explain why: _____

If the patient is currently using Kevzara, would changing the patient's current regimen likely result in adverse effects for the patient?

☐ Yes ☐ No

If yes, please explain: _____
