PriorityHealth

Pharmacy Prior Authorization Form

For Prior Authorization, please fax to: 877 974-4411 toll free, or 616 942-8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)**
☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)
Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

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: ____________

Product and Billing Information

☐ New request ☐ Continuation request

Drug product:
☐ Kevzara 150 mg prefilled syringe
☐ Kevzara 200 mg prefilled syringe
☐ Kevzara 150 mg prefilled pen
☐ Kevzara 200 mg prefilled pen

Start date (or date of next dose): ______________________
Date of last dose (if applicable): ______________________
Dosing frequency: ______________________
Patient's weight: ______________________

Place of administration:
☐ Self-administered
☐ Physician's office
☐ Outpatient infusion
Facility: ____________ NPI:____________ Fax:____________
☐ Home infusion
Facility: ____________ NPI:____________ Fax:____________

Billing:
☐ Physician to buy and bill
☐ Facility to buy and bill
☐ Specialty Pharmacy
Pharmacy:____________ NPI:____________ Fax:____________

ICD code(s): ______________________

KEVZARA COVERAGE POLICY

- Before Kevzara is covered, the patient must meet all of the General Criteria for Kevzara and all of the Specific Criteria for the treatment diagnosis. If these criteria are not met, the prescriber must provide an explanation of why an exception to the criteria is necessary.
- Coverage for a diagnosis not listed below will be considered on a case by case basis. Please provide rationale for use and all pertinent patient information.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 09/2018
Last reviewed 09/2018

- Kevzara will not be covered in combination with another biologic.
- Please provide rationale when requesting any dose or dosing interval not listed in the FDA label.

Criteria

General Initiation Criteria for ALL Diagnoses:

a) Patient has evidence of a negative TB test result in the past 12 months (or TB is adequately managed); AND
b) Prescriber is a specialist or has consulted with a specialist for the disease being treated.

Specific Criteria for Individual Diagnoses:

1. Rheumatoid Arthritis
   a) Patient has tried at least ONE conventional synthetic DMARD (such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine) for a period of at least 3 months; AND
   b) Patient has tried TWO of the following: Actemra, Enbrel, Humira, or Xeljanz/XR, each for a period of at least 3 months.

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Rheumatoid arthritis
☐ Other – the patient's condition is: ________________
Rationale for use: ____

B. Which of the following has the patient had a documented therapeutic trial with?

☐ Methotrexate Dates of therapy: ________________________________
☐ Leflunomide Dates of therapy: ________________________________
☐ Hydroxychloroquine Dates of therapy: ________________________________
☐ Sulfasalazine Dates of therapy: ________________________________
☐ Actemra Dates of therapy: ________________________________
☐ Enbrel Dates of therapy: ________________________________
☐ Humira Dates of therapy: ________________________________
☐ Xeljanz Dates of therapy: ________________________________
☐ Other Drug: ________________ Dates of therapy: __________________________

C. Has the patient had a negative TB test result in the past 12 months?

☐ Yes Date: ________________
☐ No, rationale for use: ____

D. Will the patient be receiving other biologic therapy in combination with Kevzara?

☐ No
☐ Yes, rationale for use: ____

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 09/2018
Last reviewed 09/2018