Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Kevzara (sarilumab) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Kevzara (sarilumab).** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at:** Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Provider Name: _____ Specialty: _____ Provider NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

Please check the boxes that apply:
□ Initial Request □ Continuation of Therapy Request

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

Initial Therapy:

1. Does the member have diagnosis of one of the following? **AND**
   □ Rheumatoid Arthritis (RA)

   □ Diagnosis of Polymyalgia Rheumatica (PMR)

   □ Other: _____

2. Is the patient ≥18 years old? **AND**

   □ No □ Yes

3. Is this prescribed by or in consultation with a rheumatologist? **AND**

   □ No □ Yes

If this is being used for <u>Rheumatoid Arthritis</u> (RA):

4. Does the patient have a history of failure, contraindication, or intolerance to one non-biologic disease-modifying anti-rheumatic drug (DMARD) [e.g., Rheumatrex /Trexall (methotrexate), Arava (leflunomide), Azulfidine (sulfasalazine)? **AND**

   □ No □ Yes If yes, list the products and the outcome of therapy: _____

If this is being used for <u>Polymyalgia Rheumatica</u> (PMR):

5. Does the patient have a history of failure, contraindication, or intolerance to corticosteroids?

   □ No □ Yes

Renew Criteria:

1. Is the patient receiving Kevzara in combination with any of the following?
   i. Biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]
   ii. Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
   iii. Phosphodiesterase 4 (PDE4) inhibitor [e.g. Otezla (apremilast)

   □ No □ Yes (if yes, PA will not be approved)
2. Does the member have a documented clinically significant benefit from medication?

   □ No □ Yes

6 – Provider Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**