Kevzara (sarilumab)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
□ Moderately to severely active rheumatoid arthritis □ Polymyalgia rheumatica(PMR) □ Polyarticular Juvenile Idiopathic Arthritis(pJIA) □ Other Diagnosis_____ICD-10 Code(s):_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Will drug be used in combination with a clinical trial?

Is Kevzara prescribed by a rheumatologist? □ Yes □ No

Is the patient on concurrent treatment with another biologic or immunomodulatory agent? □ Yes □ No

If so, will that biologic be discontinued when Kevzara(sarilumab) is started? □ Yes □ No

Has the patient tried and failed at least a three month treatment with the biosimilar for Humira- adalimumab-aacf? □ Yes □ No Please provide documentation.

<u>Initial Request for moderately to severe active rheumatoid arthritis</u>:

Has the patient had a trial and inadequate response of methotrexate (or another oral disease modifying anti-rheumatic agent [DMARD] such as Imuran [azathioprine], Ridaura [auranofin], Plaquenil(hydroxychloroquine), sulfasalzaine, Arava [leflunomide])? □ Yes □ No Please provide documentation.

<u>Initial Request for polymyalgia rheumatica</u>:
Has patient had a history of being treated for at least 8 weeks with prednisone of greater than or equal to 10mg/day or the equivalent corticosteroid? □ Yes □ No Please provide documentation.

Has patient had at least one episode of unequivocal PMR flare while attempting to taper prednisone at a dose that was greater than or equal to 7.5mg/day or the equivalent corticosteroid within the past 12 weeks? □ Yes □ No Please provide documentation.

Does patient have an erythrocyte sedimentation rate(ESR) of greater than or equal to 30mm/hr and/or a C-reactive protein(CRP) greater than or equal to 10mg/L? □ Yes □ No Please provide documentation.

Does patient have giant cell arteritis? □ Yes □ No
Does patient have active fibromyalgia? □ Yes □ No
Does patient have concurrent rheumatoid arthritis, or other inflammatory arthritis or other connective tissue diseases, such as but not limited to systemic lupus erythematosus, systemic sclerosis, vasculitis, myositis, missed connective tissue disease, or ankylosing spondylitis? □ Yes □ No Please provide documentation.

<u>For diagnosis of polyarticular juvenile idiopathic arthritis</u>:
Does patient weigh 63kg or greater? □ Yes □ No Please provide documentation.

Has patient tried and failed previous therapy with oral disease modifying anti-rheumatic agents (DMARDs) *[e.g. for JIA: methotrexate or sulfasalazine or leflunamide]* ? □ Yes □ No Please provide documentation.

Is patient a child (age 2-17 years) with axial spondyloarthopathy? □ Yes □ No Please provide documentation.

<u>Reauthorization:</u>
Has patient had a positive clinical response to therapy? □ Yes □ No Please provide documentation.

Is prescriber a rheumatologist? □ Yes □ No

Is the patient on concurrent treatment with another biologic or immunomodulatory agent? □ Yes □ No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ Date: _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP-4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 877-228-7909