US Family Health Plan

Prior Authorization Request Form for

Sarilumab (Kevzara)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

For Polymyalgia Rheumatica, prior authorization expires after 12 months
İnitial USFHP prior authorization is required and approved for 1 year. Renewal PA criteria is required and will be approved indefinitely.
Clinical documentation may be required for approval.

Step 1

Please complete patient and physician information (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2

Please complete clinical assessment:

1. Is the request for a diagnosis of polymyalgia rheumatica?	☐ Yes proceed to question **2**	☐ No proceed to question **4**
2. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Kevzara.*	☐ Yes (subject to verification) proceed to question **3**	☐ No proceed to question **10**
3. Has the patient had a positive response to therapy?	☐ Yes (subject to verification) **Sign and date below**	☐ No **STOP** **Coverage not approved**
4. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	☐ Yes Proceed to question **5**	☐ No Proceed to question **7**
5. Has the patient had an inadequate response to Humira?	☐ Yes Proceed to question **8**	☐ No Proceed to question **6**
6. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
7. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**

8. Is the request for a diagnosis of moderate to severe active rheumatoid arthritis?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Has the patient had an inadequate response to at least 1 disease modifying anti-rheumatic drug (DMARD)?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
10. Is the requested medication being prescribed by or in consultation with a rheumatologist?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Has the patient tried and/or failed ONE systemic corticosteroid?	☐ Yes Proceed to question **13**	☐ No Proceed to question **12**
12. Is the patient a candidate for corticosteroid therapy?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **13**
13. Is the patient 18 years of age or older?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. Does the patient have platelets less than 150,000/mm3 or liver transaminases above 1.5 times upper limit of normal (UNL)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **15**
15. Does the patient have evidence of a negative TB test result in the past 12 months (or TB is adequately managed)?	☐ Yes Proceed to question **16**	☐ No **STOP** **Coverage not approved**
16. Will the patient be receiving other targeted immunomodulatory biologics with Kevzara, including but not limited to the following: Actemra, Cimzia, Cosentyx, Enbrel, Humira, Ilumya, Kineret, Olumiant, Orencia, Otezla, Remicade, Rituxan, Siliq, Simponi, Stelara, Taltz, Tremfya, Xeljanz or Xeljanz XR?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

_____ _____

Prescriber Signature Date