

USFHP 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

<https://www.usfamilyhealth.org/for-providers/pharmacy-information/>

For Polymyalgia Rheumatica, prior authorization expires after 12 months. Renewal PA criteria will be approved indefinitely.
For renewal of therapy, an initial Tricare prior authorization approval is required. Clinical documentation may be required.

Step 1 Please complete patient and physician information (please print):

1	Patient Name: _____	Physician Name: _____
	Address: _____	Address: _____
	Sponsor ID # _____	Phone #: _____
	Date of Birth: _____	Secure Fax #: _____

Step 2 Please complete clinical assessment:

1. Is the requested medication being prescribed by or in consultation with a rheumatologist?	☐ Yes Proceed to question 2	☐ No STOP Coverage not approved
2. Is the request for a diagnosis of polymyalgia rheumatica?	☐ Yes proceed to question 3	☐ No proceed to question 5
3. Has the patient received this medication under the TRICARE benefit in the last 6 months? <i>Please choose "No" if the patient did not previously have a TRICARE approved PA for Kevzara.</i>	☐ Yes (subject to verification) proceed to question 4	☐ No proceed to question 13
4. Has the patient had a positive response to therapy?	☐ Yes (subject to verification) Sign and date below	☐ No STOP Coverage not approved
5. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	☐ Yes Proceed to question 6	☐ No Proceed to question 8
6. Has the patient had an inadequate response to Humira?	☐ Yes Proceed to question 9	☐ No Proceed to question 7
7. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes Proceed to question 9	☐ No STOP Coverage not approved
8. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes Proceed to question 9	☐ No STOP Coverage not approved

9. Is the request for a diagnosis of moderate to severe active rheumatoid arthritis?	☐ Yes Proceed to question 12	☐ No Proceed to question 10
10. Is the request for a diagnosis of active polyarticular juvenile idiopathic arthritis (pJIA)?	☐ Yes Proceed to question 11	☐ No STOP Coverage not approved
11. Does the patient weigh 63 kg or more?	☐ Yes Proceed to question 12	☐ No STOP Coverage not approved
12. Has the patient had an inadequate response or intolerance to at least ONE disease modifying anti-rheumatic drug (DMARD)? Please Note: DMARD can be a biologic or a non-biologic DMARD.	☐ Yes Proceed to question 15	☐ No STOP Coverage not approved
13. Has the patient tried and/or failed ONE systemic corticosteroid?	☐ Yes Proceed to question 15	☐ No Proceed to question 14
14. Is the patient a candidate for corticosteroid therapy?	☐ Yes STOP Coverage not approved	☐ No Proceed to question 15
15. Will the patient be receiving other targeted immunomodulatory biologics with Kevzara, including but not limited to the following: TNF inhibitors, IL-1, IL-6, IL-17, IL-23, IL-36, S1p, JAK inhibitors?	☐ 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

[08 January 2025]