# SENTARA COMMUNITY PLAN
# (MEDICAID)

## PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

**Directions**: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

**Drug Requested: Kevzara®** (sarilumab) **Injection (Non-Preferred)**

**MEMBER & PRESCRIBER INFORMATION:** Authorization may be delayed if incomplete.

**Member Name:** _____

**Member Sentara #:** _____ **Date of Birth:** _____

**Prescriber Name:** _____

**Prescriber Signature:** _____ **Date:** _____

**Office Contact Name:** _____

**Phone Number:** _____ **Fax Number:** _____

**NPI #:** _____

**DRUG INFORMATION:** Authorization may be delayed if incomplete.

**Drug Name/Form/Strength:** _____

**Dosing Schedule**: _____ **Length of Therapy**: _____

**Diagnosis:** _____ **ICD Code, if applicable:** _____

**Weight (if applicable):** _____ **Date weight obtained:** _____

**Quantity Limit**: Two syringes per 28 days. Pre-Filled syringe single-dose use, 150mg/1.14mL or 200mg/1.4mL solution

**CLINICAL CRITERIA:** Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ **Diagnosis: Moderate-to- Severe Rheumatoid Arthritis**

**Dosing: SUBQ: 200 mg once every 2 weeks (Two syringes per 28 days)**

**Initial Authorization: 12 months**

- ❑ Member age is 18 years of age or older
- ❑ Prescribed by or in consultation with a rheumatologist

**(Continued on next page)**

- ❑ Member has a diagnosis of moderate to severe active rheumatoid arthritis
- ❑ Member has a history of failure, contraindication, or intolerance to **ONE (1)** non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., Rheumatrex® /Trexall® (methotrexate), Arava® (leflunomide), Azulfidine® (sulfasalazine)]
- ❑ Tried and failed **BOTH** of the preferred therapies below:

| | |
|---|---|
| ❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd) | ❑ Enbrel® |

**Reauthorization Approval: 12 months.** Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member is not receiving Kevzara® in combination with any of the following:
  - Biologic DMARD [e.g., Enbrel® (etanercept), Humira® (adalimumab), Cimzia® (certolizumab), Simponi® (golimumab)]
  - Janus kinase inhibitor [e.g., Xeljanz® (tofacitinib)]
  - Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla® (apremilast)]
- ❑ Documentation of positive clinical response to Kevzara® therapy (Chart notes must be attached)

**❑ Diagnosis: Polymyalgia Rheumatica**

**Dosing: SUBQ: 200 mg once every 2 weeks (Two syringes per 28 days)**

**Initial Authorization: 12 months**

- ❑ Member is 18 years of age or older
- ❑ Member has a diagnosis of Polymyalgia Rheumatica (PMR)
- ❑ Prescribed by or in consultation with a Rheumatologist
- ❑ Member has a history of failure, contraindication, or intolerance to corticosteroids or cannot tolerate a steroid taper

**Reauthorization Approval: 12 months.** Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member is not receiving Kevzara® in combination with any of the following:
  - Biologic DMARD [e.g., Enbrel® (etanercept), Humira® (adalimumab), Cimzia® (certolizumab), Simponi® (golimumab)]
  - Janus kinase inhibitor [e.g., Xeljanz® (tofacitinib)]
  - Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla® (apremilast)]
- ❑ Documentation of positive clinical response to Kevzara® therapy (Chart notes must be attached)

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| ❑ **Diagnosis: Active Polyarticular Juvenile Idiopathic Arthritis (pJIA)** |
|---|
| **Dosing: SUBQ: 200 mg once every 2 weeks (Two syringes per 28 days)** |
| **Initial Authorization: 12 months** |

- ❑ Member has a diagnosis of active juvenile idiopathic arthritis
- ❑ Member is 2 years or older and weighs 63 kg or more
- ❑ Prescribed by or in consultation with a Rheumatologist
- ❑ Member has a history of failure, contraindication, or intolerance to **ONE (1)** non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., Rheumatrex® /Trexall® (methotrexate), Arava® (leflunomide), Azulfidine® (sulfasalazine)]
- ❑ Tried and failed **BOTH** of the preferred therapies below:

| | |
|---|---|
| ❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd) | ❑ Enbrel® |

**Reauthorization Approval: 12 months.** Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member is not receiving Kevzara® in combination with any of the following:
  - Biologic DMARD [e.g., Enbrel® (etanercept), Humira® (adalimumab), Cimzia® (certolizumab), Simponi® (golimumab)]
  - Janus kinase inhibitor [e.g., Xeljanz® (tofacitinib)]
  - Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla® (apremilast)]
- ❑ Documentation of positive clinical response to Kevzara® therapy (Chart notes must be attached)

**Medication being provided by (check applicable box(es) below):**

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy – PropriumRx**

***Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.***

**Previous therapies will be verified through pharmacy paid claims or submitted chart notes.***



**REVISED/UPDATED/REFORMATTED:** ~~10/31/2018; 11/18/2018; 4/6/2019;6/28/2021; 7/8/2022; 6/12/2023; 6/23/2023; 12/20/2023; 8/27/2024; 10/17/2025;~~ **12/16/2025**