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 who have had an inadequate response or intolerance to one or more disease-modifying anti-rheumatic drugs
- ❑ 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®

❑ 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

❑ 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 trial and failure of either oral non-steroidal anti-inflammatory drugs (NSAIDs) OR one conventional synthetic disease modifying anti-rheumatic drug (csDMARD) (e.g. methotrexate, azathioprine, hydroxychloroquine, penicillamine, sulfasalazine, leflunomide, etc.)
- ❑ Tried and failed **BOTH** of the preferred therapies below:

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

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; 1/20/2026;~~ **7.14.2026**