SENTARA HEALTH PLANS

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 information provided is not complete, correct, or legible, authorization may be delayed.**

Drug Requested: Kevzara® (sarilumab)

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:** _____

NOTE: The Health Plan considers the use of concomitant therapy with more than one biologic immunomodulator (e.g., Dupixent, Entyvio, Humira, Rinvoq, Stelara) prescribed for the same or different indications to be experimental and investigational. Safety and efficacy of these combinations has **NOT** been established and will **NOT** be permitted.

- ❑ Will the member be discontinuing a previously prescribed biologic if approved for requested medication?
  ❑ Yes **OR** ❑ No
- ❑ If yes, please list the medication that will be discontinued and the medication that will be initiated upon approval along with the corresponding effective date.

  Medication to be discontinued: _____ **Effective date:** _____

  Medication to be initiated: _____ **Effective date:** _____

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.

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❑ Diagnosis: Moderate-to-Severe Active Rheumatoid Arthritis

Dosing: SUBQ: 200 mg once every 2 weeks

- ❑ Member has a diagnosis of moderate-to-severe active **rheumatoid arthritis**
- ❑ Prescribed by a **Rheumatologist**
- ❑ Member has tried and failed at least **ONE** of the following **DMARD** therapies for at least three **(3) months (verified by chart notes or pharmacy paid claims)**
  - ❑ hydroxychloroquine
  - ❑ leflunomide
  - ❑ methotrexate
  - ❑ sulfasalazine
- ❑ Member meets **ONE** of the following:
  - ❑ Member tried and failed, has a contraindication, or intolerance to **TWO** of the **PREFERRED** biologics below **(verified by chart notes or pharmacy paid claims)**:

❑ Preferred adalimumab product	❑ Enbrel®
❑ Rinvoq®/Rinvoq® LQ	❑ Preferred tocilizumab product: Actemra® SC or Tyenne® SC
❑ Xeljanz®/XR®	

  - ❑ Member has been established on Kevzara® for at least 90 days **AND** prescription claims history indicates **at least a 90-day supply of Kevzara was dispensed within the past 130 days (verified by chart notes or pharmacy paid claims)**

❑ Diagnosis: Polymyalgia Rheumatica

Dosing: SUBQ: 200 mg once every 2 weeks

- ❑ Member is 50 years of age or older
- ❑ Prescribed by a **Rheumatologist**
- ❑ Member has a diagnosis of **polymyalgia rheumatica** defined by the European League Against Rheumatism/American College of Rheumatology classification criteria
- ❑ Member has a history of acute onset of proximal muscle pain and stiffness in the neck, shoulders, upper arms, hips and thighs
- ❑ Member is currently taking at least 7.5 mg/day of prednisone (or equivalent)
- ❑ Member has tried and failed methotrexate for at least **three (3) months (verified by chart notes or pharmacy paid claims)**

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❑ Diagnosis: Active Polyarticular Juvenile Idiopathic Arthritis (pJIA)

Dosing: SUBQ: 200 mg once every 2 weeks

- ❑ Member has a diagnosis of active polyarticular **juvenile idiopathic arthritis**
- ❑ Member weighs 63 kg or greater
- ❑ Prescribed by or in consultation with a **Rheumatologist**
- ❑ Member has tried and failed at least **ONE** of the following **DMARD** therapies for at least **three (3) months**
  - ❑ cyclosporine
  - ❑ hydroxychloroquine
  - ❑ leflunomide
  - ❑ methotrexate
  - ❑ Non-steroidal anti-inflammatory drugs (NSAIDs)
  - ❑ oral corticosteroids
  - ❑ sulfasalazine
  - ❑ tacrolimus
- ❑ Member meets **ONE** of the following:
  - ❑ Member tried and failed, has a contraindication, or intolerance to **TWO** of the following **PREFERRED** biologics:

❑ Preferred adalimumab product	❑ Enbrel®
❑ Rinvoq®/Rinvoq® LQ	❑ Preferred tocilizumab product: Actemra® SC or Tyenne® SC
❑ Xeljanz® tablets/oral solution	

  - ❑ Member has been established on Kevzara® for at least 90 days **AND** prescription claims history indicates **at least a 90-day supply of Kevzara was dispensed within the past 130 days (verified by chart notes or pharmacy paid claims)**

Medication being provided by Specialty Pharmacy – Proprium Rx

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.*