pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

KEVZARA (sarilumab) [non-preferred] PRIOR AUTHORIZATION FORM

Cytokine and CAM Antagonists and **Quantity Limits/Daily Dose Limits** prior authorization guidelines are accessible on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	# of pages: ________	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Product requested: ☐Kevzara 150 mg/1.14 ml syringe ☐Kevzara 150 mg/1.14 ml pen injector ☐Kevzara 200 mg/1.14 ml syringe ☐Kevzara 200 mg/1.14 ml pen injector ☐Kevzara: ________________		
Directions:	Quantity:	Refills:
Diagnosis (*submit documentation*):	Diagnosis code (*required*):	
Specialty Pharmacy Drug Program: Which specialty pharmacy will be used? ☐Diplomat Specialty ☐Walgreen's Specialty		

INITIAL requests

1. Check all that apply to the beneficiary and *submit documentation for each*. ☐vaccinated for hepatitis B ☐screened for hepatitis B (surface antigen & core antibody) ☐has been using Kevzara in the past 90 days ☐screened for tuberculosis ☐up-to-date with all age-appropriate immunizations		
2. Does the beneficiary have active hepatic disease or hepatic impairment?	☐Yes ☐No	*Submit documentation.*
3. Does the beneficiary have a history of trial and failure, contraindication, or intolerance of at least 3 months of treatment with methotrexate or another DMARD?	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
4. Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred agents? *Check all that apply.* ☐Humira ☐Xeljanz	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
5. ***For a diagnosis other than the approved indication(s),*** submit documentation supporting the use of Kevzara for the beneficiary's diagnosis & other treatments tried.		

RENEWAL requests

1. Since starting Kevzara, did the beneficiary experience a positive clinical response and/or improved level of functioning?	☐Yes ☐No	*Submit documentation of clinical response.*
2. Does the beneficiary have active hepatic disease or hepatic impairment?	☐Yes ☐No	*Submit documentation.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date:**

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