AvMed

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 1-305-671-0200**. 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)

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

Member Name: _____

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

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

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

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

Diagnosis: _____ **ICD Code:** _____

Weight: _____ **Date:** _____

NOTE: AvMed Health 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.

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 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**

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- ❑ 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)**:

❑ Actemra® SC	❑ adalimumab product: Humira®, Cyltezo® or Hyrimoz®	❑ Enbrel®
❑ Rinvoq®	❑ 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)**

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: 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)**

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.****