Mountain Pacific
INNOVATING BETTER HEALTH

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Montana Healthcare Programs Prior Authorization Request Form for Use of Kevzara® (sarilumab)

Member Name:	DOB:	Date:
Member ID:	Prescriber Phone:	
Prescriber Name/Specialty if applicable:	Prescriber Fax:	
Dosage Requested:		

Please complete below information for applicable situation, **Initiation** or **Continuation** of therapy:

☐ **INITIATION OF THERAPY**

Please check appropriate diagnosis and complete corresponding information:

Rheumatoid Arthritis

1. Member is 18 years of age or older: ☐ Yes ☐ No
2. Member has a diagnosis of moderately to severely active rheumatoid arthritis: ☐ Yes ☐ No
3. Medication is prescribed by or in consultation with a rheumatologist: ☐ Yes ☐ No

   Action required: If not in a specialty clinic or written by a specialist, copy of annual specialty consult with an appropriate specialist is required (please attach copy of consult):

   Name of specialist: _____ Contact date: _____
4. Member has trialed and had an inadequate response or intolerance to one or more disease-modifying antirheumatic drugs (DMARDs): ☐ Yes ☐ No

   Drug name: _____ Dates of use: _____

   Drug name: _____ Dates of use: _____
5. Member has had a trial and inadequate response or contraindication to a preferred drug with the same indication from the Montana Healthcare Programs Preferred Drug List (unless preferred product[s] do not have the appropriate indication): ☐ Yes ☐ No

   Drug name: _____ Dates of use: _____
6. Provider attests they have reviewed the black box warning: ☐ Yes ☐ No
7. Provider attests member **will not** use Kevzara® concomitantly with other biologics: ☐ Yes ☐ No

LIMITATIONS

Maximum daily dose: 200mg subcutaneously every 2 weeks

Initial authorization will be issued for 1 year.

Polymyalgia Rheumatica

1. Member is 18 years of age or older: ☐ Yes ☐ No
2. Member has a diagnosis of polymyalgia rheumatica: ☐ Yes ☐ No
3. Medication is prescribed by or in consultation with a rheumatologist: ☐ Yes ☐ No

   Action required: If not in a specialty clinic or written by a specialist, copy of annual specialty consult with an appropriate specialist is required (please attach copy of consult):

   Name of specialist: _____ Contact date: _____
4. Member has trialed and had an inadequate response or intolerance to corticosteroids or cannot tolerate a corticosteroid taper: ☐ Yes ☐ No

   Drug name: _____ Dates of use: _____

   If unable to trial a corticosteroid taper, please indicate why: _____

   _____

   _____
5. Member has had a trial and inadequate response or contraindication to a preferred drug with the same indication from the Montana Healthcare Programs Preferred Drug List (unless preferred product[s] do not have the appropriate indication): ☐ Yes ☐ No

   Drug name: _____ Dates of use: _____
6. Provider attests they have reviewed the black box warning: ☐ Yes ☐ No
7. Provider attests member **will not** use Kevzara® concomitantly with other biologics: ☐ Yes ☐ No

LIMITATIONS:
Maximum daily dose: 200mg subcutaneously every 2 weeks

Initial authorization will be issued for 1 year.

☐ **CONTINUATION OF THERAPY**

Rheumatoid Arthritis and Polymyalgia Rheumatica

1. Member has documentation of positive clinical response to therapy (reduction in the frequency and/or severity of symptoms and exacerbations): ☐ Yes ☐ No
2. Provider attests member will not use Kevzara® concomitantly with other biologics: ☐ Yes ☐ No
3. Annual specialist consult attached if prescriber is not a specialist: ☐ Yes ☐ No ☐ N/A - prescriber is a specialist.

LIMITATIONS:
Maximum daily dose: 200mg subcutaneously every 2 weeks

Reauthorization will be issued for 1 year.

Please complete form, including required attachments, and fax to Drug Prior Authorization Unit at 1-800-294-1350.