

Prior Authorization
JOHNS HOPKINS HEALTH PLANS Kevzara - Priority Partners MCO
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at 1-410-424-4607 . Please contact Johns Hopkins Health Plans at 1-888-819-1043 with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of Kevzara - Priority Partners MCO.

Drug Name (select from list of drugs shown) Kevzara (sarilumab)
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Quantity	Frequency	Strength
Route of Administration	Expected Length of Therapy	

Patient Information	
Patient Name:	_____
Patient ID:	_____
Patient Group No.:	_____
Patient DOB:	_____
Patient Phone:	_____

Prescribing Physician	
Physician Name:	_____
Physician Phone:	_____
Physician Fax:	_____
Physician Address:	_____
City, State, Zip:	_____

Diagnosis: _____	ICD Code: _____
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Comments: _____

Please circle the appropriate answer for each question.	
1. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.	
[If yes, skip to question 14.]	
2. Does the patient have any of the following diagnoses: A) uveitis, B) sarcoidosis, C) graft-versus-host disease, D)	<input type="checkbox"/> Y <input type="checkbox"/> N

interleukin-2 toxicity, E) Langerhans cell histiocytosis, F) myositis, G) nephrotic syndrome, H) amyloidosis, I) periodic fever syndrome, J) renal transplant syndrome, K) moderate to severe Crohn's disease in pediatric patients (as first-line therapy), L) definitive radiographic axial spondyloarthritis with evidence of structural damage on sacroiliac joints?	
[If yes, no further questions.]	
3. Has the patient previously received biologic therapy?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, skip to question 6.]	
4. Has the patient undergone tuberculosis screening within the past year?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
5. Does the patient have an active tuberculosis infection prior to starting the requested biologic therapy?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If yes, no further questions.]	
6. Does the patient have a diagnosis of moderately to severely active rheumatoid arthritis?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, skip to question 10.]	
7. Has the patient had treatment failure with at least two formulary disease-modifying antirheumatic drugs (DMARDs) including methotrexate?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If yes, skip to question 13.]	
8. Does the patient have a contraindication to at least two formulary disease-modifying antirheumatic drugs (DMARDs) including methotrexate?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If yes, skip to question 13.]	
9. Has the patient had rheumatoid arthritis for less than or equal to 6 months with high level of disease activity and features of poor prognosis (such as extra-articular disease, positive rheumatoid factor, or bony erosions)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If yes, skip to question 13.]	
[If no, no further questions.]	
10. Does the patient have a diagnosis of polymyalgia rheumatica?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	

11. Has the patient had an inadequate response, or contraindication to a trial of corticosteroids, evidenced by a breakthrough flare?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If yes, skip to question 13.]	
12. Is the patient unable to tolerate a corticosteroid taper, evidenced by symptoms of a breakthrough flare (shoulder and/or hip girdle pain associated with inflammatory stiffness)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
13. Is the patient 18 years of age or older?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, skip to question 16.]	
[If no, no further questions.]	
14. Does the patient have any of the following diagnoses: A) uveitis, B) sarcoidosis, C) graft-versus-host disease, D) interleukin-2 toxicity, E) Langerhans cell histiocytosis, F) myositis, G) nephrotic syndrome, H) amyloidosis, I) periodic fever syndrome, J) renal transplant syndrome, K) moderate to severe Crohn's disease in pediatric patients (as first-line therapy), L) definitive radiographic axial spondyloarthritis with evidence of structural damage on sacroiliac joints?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
15. Is the patient experiencing clinical improvement from treatment as supported by one of the following outcomes: A) reduction in the signs and symptoms, B) prolonged beneficial clinical response, C) inhibition of structural damage progression, or D) improved physical functioning?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
16. Is the requested drug being prescribed for FDA-approved dosages and dosing intervals?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
17. Will the requested drug be used concurrently with another biologic disease-modifying anti-rheumatic drug (DMARD)?	<input type="checkbox"/> Y <input type="checkbox"/> N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

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Prescriber (Or Authorized) Signature and Date