TRICARE Prior Authorization Request Form for
sarilumab (Kevzara)

JOHNS HOPKINS
HEALTH PLANS
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

Fax Completed Form and Applicable Progress Notes to:
(410) 424-4037

To be completed by requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

For Polymyalgia Rheumatica, prior authorization expires after 12 months. Renewal PA criteria will be approved indefinitely. For renewal of therapy, an initial Tricare prior authorization approval is required.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete clinical assessment:**

Question		
1. What is the indication or diagnosis?	☐ Moderate to severe active rheumatoid arthritis – proceed to question **4** ☐ Polymyalgia Rheumatica – proceed to question **2** ☐ Other indication or diagnosis – **STOP: Coverage not approved**	
2. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Rinvoq ER.*	☐ Yes (subject to verification) proceed to question **3**	☐ No proceed to question **9**
3. Has the patient had a positive response to therapy?	☐ Yes (subject to verification) **Sign and date below**	☐ No **STOP** **Coverage not approved**
4. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	☐ Yes Proceed to question **5**	☐ No Proceed to question **7**
5. Has the patient had an inadequate response to Humira?	☐ Yes Proceed to question **8**	☐ No Proceed to question **6**
6. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**

7. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Has the patient had an inadequate response to at least 1 disease modifying anti-rheumatic drug (DMARD)?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
9. Is the requested medication being prescribed by or in consultation with a rheumatologist?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Has the patient tried and/or failed ONE systemic corticosteroid?	☐ Yes Proceed to question **12**	☐ No Proceed to question **11**
11. Is the patient a candidate for corticosteroid therapy?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **12**
12. Is the patient 18 years of age or older?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Does the patient have platelets less than 150,000/mm3 or liver transaminases above 1.5 times upper limit of normal (UNL)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **14**
14. Does the patient have evidence of a negative TB test result in the past 12 months (or TB is adequately managed)?	☐ Yes Proceed to question **15**	☐ No **STOP** **Coverage not approved**
15. Will the patient be receiving other targeted immunomodulatory biologics with Kevzara, including but not limited to the following: Actemra, Cimzia, Cosentyx, Enbrel, Humira, Ilumya, Kineret, Olumiant, Orencia, Otezla, Remicade, Rituxan, Siliq, Simponi, Stelara, Taltz, Tremfya, Xeljanz or Xeljanz XR?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

____________________________ Prescriber Signature   __________ Date

[03 January 2024]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: