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Kevzara (sarilumab)
Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-474-3341.

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician:_____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #:_____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
Kevzara (sarilumab)			Specify:
7. Diagnosis:			

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

□ Yes □ No Member has had a diagnosis of Rheumatoid arthritis.
If Yes: □ Yes □ No Patient has had a diagnosis of rheumatoid arthritis in the last 730 days.

□ Yes □ No Member has had a claim for a disease-modifying antirheumatic drug (DMARD) in the last 90 days. (PLEASE NOTE: DMARDS include: Arava, Azathioprine, Azulfidine, Cyclosporine, Cyclosporine modified, Gengraf, Hydroxychloroquine, Imuran, Leflunomide, Methotrexate, Neoral, Otrexup, Plaquenil, Sandimmune, Sulfasalazine, Trexall and Xatmep.)

□ Yes □ No Member has had a history of hematologic abnormalities in the last 60 days.

□ Yes □ No Member has had a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days.

□ Yes □ No Member has had a diagnosis of active hepatic disease or hepatic impairment in the last 365 days.

□ Yes □ No Member has failed a 30-day treatment trial with at least one preferred agent(s) within the past 180 days.*

□ Yes □ No Member has a documented allergy or contraindication to preferred agents in this class.*

□ Yes □ No The requested medication is being provided and billed at the physician's office?

□ Yes □ No Patient is being treated for stage-four advanced, metastatic cancer and associated conditions.

* PLEASE NOTE: The preferred agents include Enbrel and Humira.

For the *Texas Medicaid Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at **http://www.txvendordrug.com/formulary/formulary-search.asp**.

9. Physician signature

_____ _____

Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.