



Please complete ALL information below and fax your request to 1-888-671-5285

### Kevzara® Coverage Determination Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:	Office Contact:	
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name: Select one of the following: <input type="checkbox"/> Request is for <b>GENERIC</b> <input type="checkbox"/> Request is for <b>BRAND</b> (unable to take the generic)	Strength:	Dosage Form:
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>	Directions for Use:	

Clinical Information (required)
<b>Select the Type of Coverage Determination Requested:</b> <input type="checkbox"/> <b>Prior Authorization</b> - Request is for a drug that requires prior authorization under the plan.
<b>Select the diagnosis below:</b> <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____
<b>Prescriber's Specialty:</b> Is Kevzara prescribed by a rheumatologist? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Clinical Information:</b> Is there documentation the patient has no concurrent therapy with any other biologic disease modifying anti-rheumatic drug (DMARD), e.g., tumor necrosis factor antagonists? <input type="checkbox"/> Yes <input type="checkbox"/> No Is there documentation the patient has been evaluated for active or latent tuberculosis (TB)? <input type="checkbox"/> Yes <input type="checkbox"/> No Is there documentation the patient has had inadequate response or inability to tolerate both adalimumab (Humira) and etanercept (Enbrel)? <input type="checkbox"/> Yes <input type="checkbox"/> No If "no" to the above question, is there documentation demonstrating that a trial may be inappropriate for the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No For new starts only, have at least 2 weeks passed since administration of live vaccines prior to start of therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.