FUTURE SCRIPTS

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

Kevzara® Prior Authorization 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:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Moderately to severely active rheumatoid arthritis (RA)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is Kevzara prescribed by or in consultation with a rheumatologist? ❑ **Yes** ❑ **No**

Has the patient had trial and failure, contraindication, or intolerance to one non-biologic disease modifying anti-rheumatic drug (DMARD) (e.g., Rheumatrex/Trexall [methotrexate], Arava [leflunomide], Azulfidine [sulfasalazine])? ❑ **Yes** ❑ **No**

Is this request for continuation of prior Kevzara therapy? ❑ **Yes** ❑ **No**

Select if the patient has had a trial and failure, contraindication, or intolerance to the following, or attestation demonstrating a trial may be inappropriate:

- ❑ Cimzia (certolizumab pegol)
- ❑ Humira (adalimumab)
- ❑ Simponi (golimumab) or Simponi Aria (golimumab IV)

Select if the patient has had a trial and failure, contraindication, or intolerance to the following:

- ❑ Actemra (tocilzumab)
- ❑ Xeljanz (tofacitinib) or Xeljanz XR (tofacitinib ER)

Reauthorization:

If this is a reauthorization request, answer the following:

Is there documentation the patient has had a positive clinical response to Kevzara therapy? ❑ **Yes** ❑ **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.