



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:
<input type="checkbox"/> Check if generic substitution is acceptable		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

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 (tocilizumab)
- 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?

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

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of FutureScripts. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**
Office use only: Kevzara_FSP_2019Jul-W