Prescriber Criteria Form Kevzara 2024 PA Fax 1958-A v3 010124.docx Kevzara (sarilumab) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Kevzara (sarilumab).

Drug Name: Kevzara (sarilumab)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Has the patient previously received the requested drug for any of the following: A) rheumatoid arthritis (RA), B) polymyalgia rheumatica (PMR)? [If yes, then no further questions.]	Yes	No
2	Does the patient have a diagnosis of moderately to severely active rheumatoid arthritis? [If no, then skip to question 4.]	Yes	No
3	Does the patient meet either of the following criteria: A) patient has had an inadequate response, intolerance, or contraindication to methotrexate (MTX), B) patient has had an inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD? [No further questions.]	Yes	No
4	Does the patient have a diagnosis of polymyalgia rheumatica (PMR)? [If no, then no further questions.]	Yes	No
5	Has the patient experienced an inadequate treatment response to corticosteroids? [If yes, then no further questions.]	Yes	No
6	Has the patient experienced a disease flare while attempting to taper corticosteroids?	Yes	No

Comments:	

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ Date:_____