HEALTHY U MEDICAID

PRIOR AUTHORIZATION REQUEST FORM
Kevzara for Polymyalgia Rheumatica®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for Pharmacy Customer Service for assistance at 385-425-5094

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested:

Preferred: corticosteroids, methotrexate
Non- formulary: ☐ Kevzara® (sarilumab)

Note: Kevazara for the indication of RA see PHARM-HU-065

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the request made by a rheumatologist?	☐	☐	**Please provide documentation**
2. Does the member have a diagnosis of polymyalgia rheumatic (PMR)?	☐	☐	**Please provide documentation**
3. Has the member been taking prednisone for at least 8 weeks (≥10 mg/day or equivalent)?	☐	☐	**Please provide documentation**
4. Does the member have clinical documentation show at least one episode of an PMR flare while attempting to taper prednisone, including both of the following: • Shoulder and/or hip girdle pain associated with inflammatory stiffness • Erythrocyte sedimentation rate (ESR) ≥30 mm/hr and/or C-reactive protein (CRP) ≥ 10mg/L?	☐	☐	**Please provide documentation**
5. Has the member had an adequate trial and failure of methotrexate for at least 3 months?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the requesting for reauthorization of therapy?	☐	☐	

2. Does the member have clinical documentation show absence of signs and symptoms of PMR and CRP < 10 mg/L?	☐	☐	

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.
Additional information:
Physician Signature:

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Policy: PHARM-HU- 159
Origination Date: 01/02/2024
Reviewed/Revised Date: 01/17/2024
Next Review Date: 01/17/2025
Current Effective Date: 02/01/2024