OPTIMA HEALTH PLAN

PHARMACY/MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: ***The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.***

Drug Requested: **Kevzara®** (sarilumab) **Injection** ***(Non-Preferred)***

DRUG INFORMATION: Complete information below. If incomplete, authorization process could be delayed. Attach medical documentation with lab values with this request form.

Drug Form/Strength/Month: ____

Dosing Schedule: ______________________________ **Length of Therapy:** ______________

Diagnosis: ____ **ICD Code:** ______________

***Recommended Dose*:**
200 mg once every two weeks; Pre-Filled syringe single-dose use, 150mg/1.14mL or 200 mg/1.4mL solution

CLINICAL CRITERIA: Complete below ALL lines for appropriate diagnosis. Authorization process will be delayed if boxes for diagnosis are NOT checked.

- **Prescriber is a Rheumatologist**
- Diagnosis of moderate- to-severe active rheumatoid arthritis for adult patients
  - ❑ Trial and failure of ***at least one DMARD*** for ***at least three (3) months*** (***check each tried***)**:**

❑ methotrexate	❑ azathioprine	❑ hydroxychloroquine
❑ sulfasalazine	❑ leflunomide	❑ auranofin
❑ Other: ______________________		

AND

  - ❑ Tried and failed ***two (2)*** of the ***PREFERRED*** biologics below:

❑ Humira®	❑ Cimzia®	❑ Simponi®

***Medication being provided by* (check applicable box below):**

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy: PropriumRx**

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: ____

Member Optima #: ______________________________ Date of Birth: ______________

Prescriber Name: ____

Prescriber Signature: ______________________________ Date: ______________

Office Contact Name: ____

Phone Number: ______________________ Fax Number: ______________________

DEA OR NPI #: ____

***Approved by the Pharmacy and Therapeutic Committee**: 9/21/2017
REVISED/UPDATED: 12/28/2017