Kevzara

HMSAMCD - Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-237-5512**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Patient's Phone Number: _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*ft* _____*inches*

Indicate where the drug is being dispensed:

❑ Office ❑ Outpatient Hospital ❑ Ambulatory Surgical ❑ Inpatient Hospital
❑ Off Campus Outpatient Hospital ❑ Urgent Care ❑ Emergency Room ❑ Birthing Center
❑ Military Facility ❑ Skilled Nursing Facility ❑ Nursing Facility ❑ Hospice
❑ Inpatient Psychiatric ❑ Psychiatric Residential Treatment ❑ End Stage Renal Facility
❑ Psychiatric Facility ❑ Pharmacy ❑ Other

Indicate where the drug is being administered:

❑ Ambulatory surgical ❑ Home ❑ Inpatient Hospital
❑ Office ❑ Outpatient Hospital ❑ Pharmacy

What is the ICD-10 code? _____

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512

 Kevzara HMSAMCD C19358-A – 04/2026.

Criteria Questions:

1. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Xeljanz)?

❒ Yes, *Continue to #2*

❒ No, *Continue to #2*

2. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis?

❒ Yes, *Continue to #9*

❒ No, *Continue to #3*

3. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [PPD], interferon-release assay [IGRA], chest x-ray) within 12 months of initiating therapy?

❒ Yes, *Continue to #4*

❒ No, *Continue to #4*

4. What were the results of the tuberculosis (TB) test?

❒ Positive for TB, *Continue to #5*

❒ Negative for TB, *Continue to #9*

❒ Unknown, *Continue to #9*

5. Which of the following applies to the patient?

❒ Patient has latent TB and treatment for latent TB has been initiated, *Continue to #9*

❒ Patient has latent TB and treatment for latent TB has been completed, *Continue to #9*

❒ Patient has latent TB and treatment for latent TB has not been initiated, *Continue to #9*

❒ Patient has active TB, *Continue to #9*

Indication

9. What is the diagnosis?

❒ Rheumatoid arthritis, *Continue to #100*

❒ Polymyalgia rheumatica, *Continue to #150*

❒ Polyarticular juvenile idiopathic arthritis (pJIA), *Continue to #200*

❒ Immune checkpoint inhibitor-related toxicity – inflammatory arthritis, *Continue to #250*

❒ Giant cell arteritis, *Continue to #300*

❒ Other, *No Further Questions*

Rheumatoid Arthritis

100. Has the patient been diagnosed with moderately to severely active rheumatoid arthritis (RA)?

❒ Yes, *Continue to #101*

❒ No, *Continue to #101*

101. Is the patient an adult?

❒ Yes, *Continue to #102*

❒ No, *Continue to #102*

102. Is the requested drug being prescribed by or in consultation with a rheumatologist?

❒ Yes, *Continue to #103*

❒ No, *Continue to #103*

Continuation of Therapy

103. Is this request for continuation of therapy with the requested drug?

❒ Yes, *Continue to #104*

❒ No, *Continue to #107*

104. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to #107*

❒ No, *Continue to #105*

❒ Unknown, *Continue to #107*

105. Has the patient achieved or maintained a positive clinical response since starting treatment with the requested drug?

❒ Yes, *Continue to #106*

❒ No, *Continue to #106*

106. Has the patient experienced substantial disease activity improvement (e.g., at least 20% from baseline) in tender joint count, swollen joint count, pain, or disability ?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Initial Therapy

Prior treatment with another biologic or targeted synthetic drug

107. Has the patient received or is currently receiving a biologic or targeted synthetic drug (e.g., Rinvoq, Xeljanz) within the past 120 days indicated for moderately to severely active rheumatoid arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)?

❒ Yes, *No Further Questions*

❒ No, *Continue to #108*

Biomarker testing and requirements regarding prior therapy

108. Does the patient meet either of the following: a) the patient was tested for the rheumatoid factor (RF) biomarker and the RF biomarker test was positive, or b) the patient was tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker and the anti-CCP biomarker test was positive?

❒ Yes, *Continue to #110*

❒ No, *Continue to #109*

109. Has the patient been tested for all of the following biomarkers: a) rheumatoid factor (RF), b) anti-cyclic citrullinated peptide (anti-CCP), and c) C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR)?

❒ Yes, *Continue to #110*

❒ No, *Continue to #110*

110. Has the patient failed to achieve a low disease activity after a 3-month trial of methotrexate (MTX) monotherapy at a maximum titrated dose of at least 15 mg per week?

❒ Yes, *Continue to #111*

❒ No, *Continue to #117*

111. Has the patient had an inadequate response to methotrexate in combination with at least one other conventional synthetic drug (i.e., hydroxychloroquine and/or sulfasalazine) after a 3-month trial at a maximum tolerated dose(s)?

❒ Yes, *No Further Questions*

❒ No, *Continue to #112*

112. Has the patient experienced an intolerable adverse event to hydroxychloroquine or sulfasalazine?

❒ Yes, *No Further Questions*

❒ No, *Continue to #113*

113. Does the patient have a contraindication to sulfasalazine (e.g., porphyria, intestinal or urinary obstruction)?

❒ Yes, *Continue to #114*

❒ No, *Continue to #116*

114. Does the patient have a contraindication to hydroxychloroquine?

❒ Yes, *Continue to #115*

❒ No, *Continue to #116*

115. Please indicate the contraindication to hydroxychloroquine

❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *No Further Questions*

❒ Drug interaction, *No Further Questions*

❒ Risk of treatment-related toxicity, *No Further Questions*

❒ Pregnancy or currently planning pregnancy, *No Further Questions*

❒ Breastfeeding, *No Further Questions*

❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *No Further Questions*

❒ Hypersensitivity, *No Further Questions*

❒ History of intolerance or adverse event, *No Further Questions*

❒ Other, please specify, *No Further Questions*

116. Does the patient have moderate to high disease activity?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

117. Was the patient unable to tolerate a 3-month trial of methotrexate monotherapy at a maximum titrated dose of at least 15 mg per week?

❒ Yes, *Continue to #118*

❒ No, *Continue to #125*

118. Has the patient had an inadequate response to methotrexate in combination with at least one other conventional synthetic drug (i.e., hydroxychloroquine and/or sulfasalazine) after a 3-month trial at a maximum tolerated dose(s)?

❒ Yes, *No Further Questions*

❒ No, *Continue to #119*

119. Has the patient stopped taking methotrexate and has had a documented inadequate response to another conventional synthetic drug (i.e., leflunomide, hydroxychloroquine, and/or sulfasalazine) alone or in combination after a 3-month trial at a maximum tolerated dose(s)?

❒ Yes, *No Further Questions*

❒ No, *Continue to #120*

120. Has the patient experienced an intolerable adverse event to leflunomide, hydroxychloroquine, or sulfasalazine?

❒ Yes, *No Further Questions*

❒ No, *Continue to #121*

121. Does the patient have a contraindication to sulfasalazine (e.g., porphyria, intestinal or urinary obstruction)?

❒ Yes, *Continue to #122*

❒ No, *Continue to #124*

122. Does the patient have a contraindication to leflunomide and hydroxychloroquine?

❒ Yes, *Continue to #123*

❒ No, *Continue to #124*

123. Please indicate the contraindication to leflunomide and hydroxychloroquine

❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *No Further Questions*

❒ Drug interaction, *No Further Questions*

❒ Risk of treatment-related toxicity, *No Further Questions*

❒ Pregnancy or currently planning pregnancy, *No Further Questions*

❒ Breastfeeding, *No Further Questions*

❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *No Further Questions*

❒ Hypersensitivity, *No Further Questions*

❒ History of intolerance or adverse event, *No Further Questions*

❒ Other, please specify, *No Further Questions*

124. Does the patient have moderate to high disease activity?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

125. Has the patient experienced an intolerable adverse event to methotrexate and has discontinued methotrexate?

❒ Yes, *Continue to #128*

❒ No, *Continue to #126*

126. Does the patient have a contraindication to methotrexate?

❒ Yes, *Continue to #127*

❒ No, *Continue to #127*

127. Please indicate the contraindication to methotrexate

❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to #128*

❒ Drug interaction, *Continue to #128*

❒ Risk of treatment-related toxicity, *Continue to #128*

❒ Pregnancy or currently planning pregnancy, *Continue to #128*

❒ Breastfeeding, *Continue to #128*

❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to #128*

❒ Hypersensitivity, *Continue to #128*

❒ History of intolerance or adverse event, *Continue to #128*

❒ Other, please specify, *Continue to #128*

128. Has the patient had an inadequate response to another conventional synthetic drug (i.e., leflunomide, hydroxychloroquine, and/or sulfasalazine) alone or in combination after a 3-month trial at a maximum tolerated dose(s)?

❒ Yes, *No Further Questions*

❒ No, *Continue to #129*

129. Has the patient experienced an intolerable adverse event to leflunomide, hydroxychloroquine, or sulfasalazine?

❒ Yes, *No Further Questions*

❒ No, *Continue to #130*

130. Does the patient have a contraindication to sulfasalazine (e.g., porphyria, intestinal or urinary obstruction)?

❒ Yes, *Continue to #131*

❒ No, *Continue to #133*

131. Does the patient have a contraindication to leflunomide and hydroxychloroquine?

❒ Yes, *Continue to #132*

❒ No, *Continue to #133*

132. Please indicate the contraindication to leflunomide and hydroxychloroquine

❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease, *No Further Questions*

❒ Drug interaction, *No Further Questions*

❒ Risk of treatment-related toxicity, *No Further Questions*

❒ Pregnancy or currently planning pregnancy, *No Further Questions*

❒ Breastfeeding, *No Further Questions*

❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *No Further Questions*

❒ Hypersensitivity, *No Further Questions*

❒ History of intolerance or adverse event, *No Further Questions*

❒ Other, *No Further Questions*

133. Does the patient have moderate to high disease activity?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Polymyalgia Rheumatica

150. Is the patient an adult?

❒ Yes, *Continue to #151*

❒ No, *Continue to #151*

151. Is the requested drug being prescribed by or in consultation with a rheumatologist?

❒ Yes, *Continue to #152*

❒ No, *Continue to #152*

Continuation of Therapy

152. Is this request for continuation of therapy with the requested drug?

❒ Yes, *Continue to #153*

❒ No, *Continue to #156*

153. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to #156*

❒ No, *Continue to #154*

❒ Unknown, *Continue to #156*

154. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?

❒ Yes, *Continue to #155*

❒ No, *Continue to #155*

155. Which of the following has the patient experience an improvement in from baseline?

❒ Morning stiffness, *No Further Questions*

❒ Hip or shoulder pain, *No Further Questions*

❒ Hip or shoulder range of motion, *No Further Questions*

❒ C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR), *No Further Questions*

❒ None of the above, *No Further Questions*

Initial Therapy

156. Has the patient experienced an inadequate response to systemic corticosteroids?

❒ Yes, *No Further Questions*

❒ No, *Continue to #157*

157. Has the patient experienced a disease flare during a taper with systemic corticosteroids?

❒ Yes, *No Further Questions*

❒ No, *Continue to #158*

158. Has the patient experienced an inadequate response to methotrexate

❒ Yes, *No Further Questions*

❒ No, *Continue to #159*

159. Does the patient have an intolerance or contraindication to systemic corticosteroids?

❒ Yes, *Continue to #160*

❒ No, *Continue to #160*

160. Does the patient have an intolerance or contraindication to methotrexate?

❒ Yes, *Continue to #161*

❒ No, *Continue to #161*

161. Please indicate the contraindication to methotrexate:

❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *No Further Questions*

❒ Drug interaction, *No Further Questions*

❒ Risk of treatment-related toxicity, *No Further Questions*

❒ Pregnancy or currently planning pregnancy, *No Further Questions*

❒ Breastfeeding, *No Further Questions*

❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *No Further Questions*

❒ Hypersensitivity, *No Further Questions*

❒ History of intolerance or adverse event, *No Further Questions*

❒ Other, *No Further Questions*

Polyarticular juvenile idiopathic arthritis

200. Has the patient been diagnosed with active polyarticular juvenile idiopathic arthritis?

❒ Yes, *Continue to #201*

❒ No, *Continue to #201*

201. Does the patient weigh 63 kilograms (kg) or greater?

❒ Yes, *Continue to #202*

❒ No, *Continue to #202*

202. Is the requested drug being prescribed by or in consultation with a rheumatologist?

❒ Yes, *Continue to #203*

❒ No, *Continue to #203*

203. Is this request for continuation of therapy with the requested drug?

❒ Yes, *Continue to #204*

❒ No, *Continue to #207*

204. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to #207*

❒ No, *Continue to #205*

205. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?

❒ Yes, *Continue to #206*

❒ No, *Continue to #206*

206. Which of the following has the patient experienced an improvement in from baseline?

❒ Number of joints with active arthritis (e.g., swelling, pain, limitation of motion), *No Further Questions*

❒ Number of joints with limitation of movement, *No Further Questions*

❒ Functional ability, *No Further Questions*

❒ None of the above, *No Further Questions*

207. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Xeljanz) indicated for the treatment of active polyarticular juvenile idiopathic arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)?

❒ Yes, *No Further Questions*

❒ No, *Continue to #208*

208. Has the patient had an inadequate response to methotrexate or another conventional synthetic drug (e.g., leflunomide, sulfasalazine, hydroxychloroquine) administered at an adequate dose and duration?

❒ Yes, *No Further Questions*

❒ No, *Continue to #209*

209. Has the patient had an inadequate response to a trial of scheduled non-steroidal anti-inflammatory drugs (NSAIDs) and/or intra-articular glucocorticoids (e.g., triamcinolone hexacetonide)?

❒ Yes, *Continue to #210*

❒ No, *Continue to #211*

210. Does the patient have one of the following risk factors for poor outcome: a) involvement of ankle, wrist, hip, sacroiliac joint, and/or temporomandibular joint (TMJ), b) presence of erosive disease or enthesitis, c) delay in diagnosis, d) elevated levels of inflammation markers, or e) symmetric disease?

❒ Yes, *No Further Questions*

❒ No, *Continue to #211*

211. Does the patient have any of the following risk factors for disease severity and potentially a more refractory disease course: a) positive rheumatoid factor, b) positive anti-cyclic citrullinated peptide antibodies, or c) pre-existing joint damage?

❒ Yes, *Continue to #212*

❒ No, *Continue to #212*

212. Does the patient meet any of the following: a) high-risk joints are involved (e.g., cervical spine, wrist, or hip), b) high disease activity, or c) high risk for disabling joint disease?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Immune checkpoint inhibitor-related toxicity – inflammatory arthritis

250. Is the requested drug being prescribed by or in consultation with an oncologist, hematologist, or rheumatologist?

❒ Yes, *Continue to #251*

❒ No, *Continue to #251*

251. Is this request for continuation of therapy with the requested drug?

❒ Yes, *Continue to #252*

❒ No, *Continue to #254*

252. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to #254*

❒ No, *Continue to #253*

❒ Unknown, *Continue to #254*

253. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

254. Does the patient have moderate or severe immunotherapy-related inflammatory arthritis?

❒ Yes, *Continue to #255*

❒ No, *Continue to #255*

255. Has the patient had an inadequate response to corticosteroids or a conventional synthetic drug (e.g., methotrexate, sulfasalazine, leflunomide, hydroxychloroquine)?

❒ Yes, *No Further Questions*

❒ No, *Continue to #256*

256. Does the patient have an intolerance or contraindication to corticosteroids?

❒ Yes, *Continue to #257*

❒ No, *Continue to #257*

257. Does the patient have an intolerance or contraindication to a conventional synthetic drug (e.g., methotrexate, sulfasalazine, leflunomide, hydroxychloroquine)?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Giant Cell Arteritis

300. Is the requested drug being prescribed by or in consultation with a rheumatologist?

❒ Yes, *Continue to #301*

❒ No, *Continue to #301*

301. Is this request for continuation of therapy with the requested drug?

❒ Yes, *Continue to #302*

❒ No, *Continue to #305*

302. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to #305*

❒ No, *Continue to #303*

❒ Unknown, *Continue to #305*

303. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?

❒ Yes, *Continue to #304*

❒ No, *Continue to #304*

304. Which of the following has the patient experienced an improvement in from baseline?

❒ Headaches, *No Further Questions*

❒ Scalp tenderness, *No Further Questions*

❒ Tenderness and/or thickening of superficial temporal arteries, *No Further Questions*

❒ Constitutional symptoms (e.g., weight loss, fever, fatigue, night sweats), *No Further Questions*

❒ Jaw and/or tongue claudication, *No Further Questions*

❒ Acute visual symptoms (e.g., amaurosis fugax, acute visual loss, diplopia), *No Further Questions*

❒ Symptoms of polymyalgia rheumatica (e.g., shoulder and/or hip girdle pain), *No Further Questions*

❒ Limb claudication, *No Further Questions*

❒ None of the above, *No Further Questions*

305. Has the diagnosis been confirmed by temporal artery biopsy or cross-sectional imaging?

❒ Yes, *No Further Questions*

❒ No, *Continue to #306*

306. Has the diagnosis been confirmed by acute-phase reactant elevation (i.e., high erythrocyte sedimentation rate [ESR] and/or high serum C-reactive protein [CRP])?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**