



Kevzara (sarilumab)

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			**Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.**		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		
Urgency: <input type="checkbox"/> Standard <input type="checkbox"/> Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)					
Medication Requested: <input type="checkbox"/> Kevzara 200mg prefilled syringe <input type="checkbox"/> Kevzara 150mg prefilled syringe <input type="checkbox"/> Kevzara 200mg pen injector <input type="checkbox"/> Kevzara 150mg pen injector					
Dose and Quantity:		Duration of therapy:		J-Code:	
Frequency of administration:			ICD10:		
Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples of Kevzara , please choose "new start of therapy". <input type="checkbox"/> new start of therapy <input type="checkbox"/> continued therapy					
(if continued therapy) Has your patient had a good response to therapy with this drug (such as improvement or remission)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
(if no) Please provide clinical support for the continued use of Kevzara :					
Which applies to your patient? <input type="checkbox"/> patient is established on this drug with previous approval by Cigna <input type="checkbox"/> patient is established on this drug with previous approval by another health plan <input type="checkbox"/> patient is established on this drug with regular use for more than 1 year <input type="checkbox"/> patient was previously established on this drug, and is restarting after a break in therapy Please provide the dates your patient has received Kevzara :					
Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Other (please specify): <i>*Cigna's nationally preferred specialty pharmacy</i>					
<i>**Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 Century Center Pkwy, Memphis, TN 38134-8822 NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557</i>					
Facility and/or doctor dispensing and administering medication: Facility Name: _____ State: _____ Tax ID#: _____ Address (City, State, Zip Code): _____					
Diagnosis related to use (please specify): <input type="checkbox"/> rheumatoid arthritis (RA) <input type="checkbox"/> other (please specify): _____					
Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No					

Clinical Information:

Besides the drug being requested, other biological drugs include Actemra, Cimzia, Cosentyx, Enbrel, Entyvio, Humira, Ilumya, Inflectra, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Rinvoq, Rituxan, Siliq, Simponi/Simponi Aria, Stelara, Taltz, Tremfya, Tysabri, and Xeljanz/Xeljanz XR. Which of the following best describes your patient's situation?

- The patient is NOT taking any other biological at this time, nor will they in the future. The requested drug is the only biological the patient is/will be using.
- The patient is currently on another biological, but this drug will be stopped and the requested drug will be started.
- The patient is currently on another biological, and the requested drug will be added. The patient may continue to take both drugs together.
- The patient is currently on BOTH the requested drug AND another biological.
- other/unknown

(if other/more than the requested drug) Please provide name of drug, dates taken and, if applicable, the clinical rationale for the combined use of the requested drug and another biologic to treat your patient's diagnosis.

Is there documentation that your patient has had failure, inadequate response OR intolerance to any of the following? (check all that apply):

- | | | | | | | |
|---------------------------------------|-----------------------------------|---|----------------------------------|-----------------------------------|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Actemra | <input type="checkbox"/> Cimzia | <input type="checkbox"/> Enbrel | <input type="checkbox"/> Entyvio | <input type="checkbox"/> Humira | <input type="checkbox"/> Ilumya | <input type="checkbox"/> Inflectra |
| <input type="checkbox"/> Kineret | <input type="checkbox"/> Olumiant | <input type="checkbox"/> Orencia | <input type="checkbox"/> Otezla | <input type="checkbox"/> Remicade | <input type="checkbox"/> Renflexis | <input type="checkbox"/> Rinvoq |
| <input type="checkbox"/> Rituxan | <input type="checkbox"/> Siliq | <input type="checkbox"/> Simponi (Aria) | <input type="checkbox"/> Stelara | <input type="checkbox"/> Taltz | <input type="checkbox"/> Tremfya | <input type="checkbox"/> Xeljanz (XR) |
| <input type="checkbox"/> Other: _____ | | | | | | |

Please provide drug name(s), date(s) taken and what the documented results were for each drug tried:

Is there documentation that your patient has a contraindication per FDA label or is not a candidate for any of the following? (check all that apply):

- | | | | | | | |
|---------------------------------------|-----------------------------------|---|----------------------------------|-----------------------------------|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Actemra | <input type="checkbox"/> Cimzia | <input type="checkbox"/> Enbrel | <input type="checkbox"/> Entyvio | <input type="checkbox"/> Humira | <input type="checkbox"/> Ilumya | <input type="checkbox"/> Inflectra |
| <input type="checkbox"/> Kineret | <input type="checkbox"/> Olumiant | <input type="checkbox"/> Orencia | <input type="checkbox"/> Otezla | <input type="checkbox"/> Remicade | <input type="checkbox"/> Renflexis | <input type="checkbox"/> Rinvoq |
| <input type="checkbox"/> Rituxan | <input type="checkbox"/> Siliq | <input type="checkbox"/> Simponi (Aria) | <input type="checkbox"/> Stelara | <input type="checkbox"/> Taltz | <input type="checkbox"/> Tremfya | <input type="checkbox"/> Xeljanz (XR) |
| <input type="checkbox"/> Other: _____ | | | | | | |

Please explain any contraindication OR reason why your patient is not a candidate for any drugs that were checked off:

Is there documentation that your patient either has had failure, inadequate response or intolerance OR has a contraindication per FDA label OR is not a candidate for one disease-modifying anti-rheumatic drug (DMARD) (for example, methotrexate, leflunomide, sulfasalazine)? Yes No

(Please note: there are different preferred products depending on your patient's plan. Please refer to the applicable Cigna health care professional resource [e.g. cignaforhcp.com] to determine benefit availability and the terms and conditions of coverage)

Additional pertinent information: Please include any alternatives tried, with drug name, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced.

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature: _____ **Date:** _____

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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.