

Please note: All information below is required to process this request.

Fax to 1-844-403-1029

Mon-Sat: 7am to 7pm Central

Kevzara® Prior Authorization Request Form DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)				Provider Information (required)			
Member Name:			Provider Name:	Provider Name:			
Insurance ID#:			NPI#:	NPI#: Specialty:			
Date of Birth:			Office Phone:	Office Phone:			
Street Address:		Office Fax:	Office Fax:				
City:	State:	Zip:	Office Street Addre	Office Street Address:			
Phone:	L		City:	City: State:		Zip:	
Medication Information (required)							
Medication Name:			Strength:			orm:	
☐ Check if requesting brand			Directions for Use:	Directions for Use:			
☐ Check if request is for continuation of therapy							
Clinical Information (required)							
Select the diagnosis below: Moderately to severely active rheumatoid arthritis (RA) Moderately to severely active polyarticular juvenile idiopathic arthritis (pJIA)							
□ Polymyalgia Rheumatica (PMR) □ Other diagnosis: ICD-10 Code(s):							
Clinical information: Select if the requested medication is prescribed by or in consultation with one of the following specialists: Rheumatologist Other Will Kouzara be used in combination with another biologic agent? No. 17 No. 17 No.							
Will Kevzara be used in combination with another biologic agent? Yes No For moderately to severely active rheumatoid arthritis (RA), also answer the following:							
Has the patient had an inadequate response to, intolerance to, or contraindication to one or more non-biologic disease modifying anti-rheumatic drugs (DMARDs)? Yes No List							
For moderately to severely active polyarticular juvenile idiopathic arthritis (pJIA), also answer the following:							
Has the patient had an inadequate response to, intolerance to, or contraindication to one or more non-biologic disease modifying anti- rheumatic drugs (DMARDs)? • Yes • No List							
For polymyalgia rheumatica (PMR), also answer the following: Has the patient had an inadequate response to, intolerance to, or contraindication to corticosteroids? Yes No List							
Quantity limit requests: What is the quantity requested per TREATMENT? syringe every weeks What is the reason for exceeding the plan limitations? □ Titration or loading dose purposes □ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime) □ Requested strength/dose is not commercially available □ Other:							
Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?							
F	or urgent or expedite	denied unless all required inform ed requests please call 1-855-40 d for non-urgent requests and fa)1-4262.				

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