Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Kevzara

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Request type:

☐ Initial - Go to 2 ☐ Continuation - Go to 11

Q2. Is the medication being prescribed by or in consultation with a rheumatologist?

☐ Yes ☐ No

Q3. Does the member have a documented negative tuberculosis (TB) test (which can include a tuberculosis skin test [PPD], an interferon-release assay [IGRA], or a chest x-ray) within 6 months of initiating therapy for persons who are naïve to biologic drugs or targeted synthetic drugs associated with an increased risk of TB?

☐ Yes ☐ No

Q4. Is the requested medication being used concomitantly with any other biologic drug or targeted synthetic drug?

☐ Yes ☐ No

Q5. What is the patient's diagnosis?

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Patient Name:	**Prescriber Name:**

☐ Rheumatoid arthritis (RA) - Go to 6 ☐ Polymyalgia rheumatica (PMR) - Go to 10

Q6. For moderately to severely active RA, has the patient previously received or is unable to receive a biologic or targeted synthetic drug (e.g., Rinvoq, Xeljanz) indicated for moderately to severely active rheumatoid arthritis? Please attach documentation

☐ Yes ☐ No

Q7. For moderately to severely active RA, has the patient had an inadequate response to at least a 3-month trial of methotrexate despite adequate dosing (i.e., titrated to at least 15 mg/week) OR is unable to take methotrexate?

☐ Yes ☐ No

Q8. For RA, has the patient tested positive for Rheumatoid factor (RF) and Anti-cyclic citrullinated peptide (anti-CCP)? Please attach documentation.

☐ Yes ☐ No

Q9. Has the patient been tested for RF, Anti-CCP and C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR)? Please attach documentation.

☐ Yes ☐ No

Q10. For treatment of polymyalgia rheumatica (PMR), does the member meet all of the following criteria:
A) 18 years of age or older;
B) Documented diagnosis of polymyalgia rheumatica (PMR);
C) Documented inadequate response, contraindication, or intolerance to systemic corticosteroids or steroid tapers?

☐ Yes ☐ No

Q11. For continuation, has the patient achieved or maintained a positive clinical response as evidenced by disease activity improvement of at least 20% from baseline in tender joint count, swollen joint count, pain, or disability?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q12. Additional Information:

Prescriber Signature

Date

v2025