UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for KEVZARA ®

Program	Prior Authorization
Medication	KEVZARA

1. Background:

Drugs Requiring Prior Authorization

KEVZARA 150 MG/1.14 ML SYRINGE
KEVZARA 200 MG/1.14 ML SYRINGE

2. Coverage Criteria:

A. <u>Authorization Criteria</u>

1. The patient is at least 18 years of age.

AND

2. The patient has a diagnosis of rheumatoid arthritis

Authorization will be issued for 365 days.

Program	Program type – Prior Authorization
Change Control	
Date	Change
January 1, 2017	New program