

Fax completed form to: 1-866-868-0858  
Questions, please call: 1-866-316-6049



## **Important Information About Prescription Drug Coverage**

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To: \_\_\_\_\_ From: \_\_\_\_\_

Fax: \_\_\_\_\_ Pages: \_\_\_\_\_

Re: Kineret® (anakinra): Prior Authorization Request Form: Please respond.

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- Please complete the attached Kineret® (anakinra) Prior Authorization Request Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

**Please note:** By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

### Information about this drug

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#### Kineret® (anakinra)

Kineret® is substantially excreted by the kidney with risk of toxic reactions possibly increasing in patients with impaired renal function. Kineret® should be used with caution in elderly patients due to reduced renal function. Please consider one of the following DMARD alternatives if clinically appropriate: azathioprine, hydroxychloroquine, methotrexate, sulfasalazine, leflunomide, gold (Auranofin®), penicillamine. If a biologic agent is needed, a trial of Humira® is required prior to Kineret® approval.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

**Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.**

# Prior Authorization Request Form



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## Patient Information

Name \_\_\_\_\_  
Member ID \_\_\_\_\_  
Medicare ID \_\_\_\_\_  
Date of birth \_\_\_\_\_ Sex: M / F  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_  
Nursing home resident? YES / NO  
Home care patient? YES / NO

## Prescriber and Pharmacy Information

Name \_\_\_\_\_  
Specialty \_\_\_\_\_  
DEA \_\_\_\_\_  
NPI \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Pharmacy name \_\_\_\_\_  
NCPDP \_\_\_\_\_  
NPI \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_

## All items below this line are for Physician Use Only

### Information for Requested Drug

Strength: \_\_\_\_\_ Dosage form: \_\_\_\_\_ Qty per 30 days: \_\_\_\_\_ Drug is (circle one): Newly prescribed/Refill  
Directions: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

### Kineret® (anakinra) Criteria

- Please indicate Kineret®'s dispensing location:  
 the pharmacy  
 the physician's supply, incident to a physician's visit  
 Other: \_\_\_\_\_
- Please indicate the patient's diagnosis. Select or specify the correct ICD-9 code. This question must be completed.  
 Rheumatoid Arthritis (ICD-9: 714)  
 Other (diagnosis and ICD-9): \_\_\_\_\_
- Is the prescribing physician a rheumatologist or has one been consulted?  
 Yes  No
- Does the patient have any of the following exclusion criteria (check all that apply)?  
 Yes  No  
 Septic arthritis of a native joint within the last 12 months  
 Sepsis of a prosthetic joint within the last 12 months or indefinitely if the joint remains in situ  
 NYHA grade 3 or 4 heart failure  
 Clear history of demyelinating disease  
 Active infection (e.g., chronic leg ulcers, recurrent respiratory infections, indwelling catheter, TB, hepatitis B/C, HIV)
- Is the patient's CrCl greater than or equal to 30ml/min?  
 Yes  No
- A trial of Humira® is required. Has the patient failed to receive a clinically appropriate therapeutic response OR demonstrated intolerance (e.g., allergy, hypersensitivity, adverse effects(s), development of a contraindication) from Humira® over a period of at least 30 days?  
 Yes  No
- Kineret®'s quantity limit is 28 syringes (18.76 mL) per 28 days. If you are requesting Kineret® in a quantity exceeding usual recommended doses, please provide clinical rationale below.  
 \_\_\_\_\_

Medical justification: (Attach additional page if necessary): \_\_\_\_\_

Prescriber's signature: \_\_\_\_\_ Date: \_\_\_\_\_