

# Pharmacy Prior Authorization Form

Last Reviewed: Sept. 09

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to:  Commercial Plan     Medicaid Plan     Medicare Plan

**Kineret<sup>®</sup> (anakinra)**

Urgent

Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:

Kineret single use Prefilled Syringe - 100 mg

Dose: \_\_\_\_\_ Start date: \_\_\_\_\_

Prescriber is a rheumatologist:

Yes

No

## Priority Health Precertification Requirements:

### Authorization of Kineret requires:

- Diagnosis of rheumatoid arthritis
  - Documented therapeutic trial of at least one DMARD
  - Documented therapeutic trial of Enbrel
- Negative TB test (must be done yearly)
- Patient must **not** have moderate to severe heart failure

### Continuation of Kineret therapy requires:

- Patient must be compliant taking the medication as prescribed
- Patient must be tolerating the medication
- Patient must not be experiencing any severe adverse reactions while taking the medication
- Patient must be responding positively to the medication
- Patient must have a negative TB test within the past 12 months

### Please Complete the Following Information:

Diagnosis:

Rheumatoid Arthritis

Other: \_\_\_\_\_ Please provide rationale for use: \_\_\_\_\_

Results of annual (within the past 12 months) TB test:

Positive - Rationale for use: \_\_\_\_\_

Negative

Test not done – Rationale for use: \_\_\_\_\_

Patient has moderate to severe heart failure:

- Yes – Rationale for use: \_\_\_\_\_
- No

New request or continuation of therapy:

- New (see section 1)
- Continuation (see section 2)

### Section 1 – New requests:

#### Rheumatoid Arthritis

Patient has had a therapeutic trial of at least one of the following DMARDS:

- Yes

	Dose	Dates	Outcome
<input type="checkbox"/> azathioprine	_____	_____	_____
<input type="checkbox"/> cyclosporine	_____	_____	_____
<input type="checkbox"/> d-penicillamine	_____	_____	_____
<input type="checkbox"/> gold sodium thiomalate	_____	_____	_____
<input type="checkbox"/> auranofin	_____	_____	_____
<input type="checkbox"/> aurothioglucose	_____	_____	_____
<input type="checkbox"/> hydroxychloroquine	_____	_____	_____
<input type="checkbox"/> leflunomide	_____	_____	_____
<input type="checkbox"/> methotrexate	_____	_____	_____
<input type="checkbox"/> sulfasalazine	_____	_____	_____

- No – Rationale for use: \_\_\_\_\_

Patient has had a documented therapeutic trial and clinical failure of Enbrel:

- Yes    Enbrel Dose: \_\_\_\_\_    Trial Dates: \_\_\_\_\_
- No – Rationale for use: \_\_\_\_\_

### Section 2 – Requests for continuation of therapy:

- The patient is compliant in taking the medication as scheduled
- The patient tolerated the medication
- The patient did not experience any severe adverse reactions while taking the medication
- The patient has responded to treatment, as determined by the prescribing physician
- The patient has had a negative TB test result within the past 12 months    Date of test: \_\_\_\_\_

\*\*\* All fields must be complete and legible for Prior Authorization Review\*\*\*

**Please fax this request to: (877)974-4411 toll free or (616)942-8206**

**YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**