PriorityHealth

Pharmacy
Prior Authorization Form

Last Reviewed: Sept. 11

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® (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:____

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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
☐ azathioprine	________	________	________
☐ cyclosporine	________	________	________
☐ d-penicillamine	________	________	________
☐ gold sodium thiomalate	________	________	________
☐ auranofin	________	________	________
☐ aurothioglucose	________	________	________
☐ hydroxychloroquine	________	________	________
☐ leflunomide	________	________	________
☐ methotrexate	________	________	________
☐ 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***

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX