PriorityHealth

Pharmacy Prior Authorization Form

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

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Kineret® (anakinra)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

☐ Provider is a Rheumatologist

Product Information

☐ New request ☐ Continuation request

Drug product: ☒ Kineret 100 mg/0.67 mL injection

Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Dosing frequency: _____

KINERET COVERAGE POLICY

- Before Kineret is covered, the patient must meet all of the General Criteria for Kineret and all of the Specific Criteria for the treatment diagnosis. If these criteria are not met, the prescriber must provide an explanation of why an exception to the criteria is necessary.
- Coverage for a diagnosis not listed below will be considered on a case by case basis. Please provide rationale for use and all pertinent patient information.
- Kineret will not be covered in combination with another biologic drug.
- Please provide rationale when requesting any dose or dosing interval not listed in the FDA label.

Criteria

General Criteria for ALL Diagnoses:

a) Patient has evidence of a negative TB test result in the past 12 months (or TB is adequately managed); AND
b) Prescriber is a specialist or has consulted with a specialist for the condition being treated.

Specific Criteria for Individual Diagnoses:

1. Rheumatoid Arthritis
   a) Patient has tried at least ONE synthetic DMARD (such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine) for a period of at least 3 months; AND
   b) Patient has tried TWO of the following: Actemra, Enbrel, Humira, or Xeljanz/XR, each for a period of at least 3 months.

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 09/2017
Last reviewed 09/2018

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Rheumatoid arthritis
- ☐ Other – the patient's condition is: _____
  Rationale for use: _____

B. Which of the following has the patient had a documented therapeutic trial with?

- ☐ Methotrexate Dates of therapy: _____
- ☐ Leflunomide Dates of therapy: _____
- ☐ Hydroxychloroquine Dates of therapy: _____
- ☐ Sulfasalazine Dates of therapy: _____
- ☐ Actemra Dates of therapy: _____
- ☐ Enbrel Dates of therapy: _____
- ☐ Humira Dates of therapy: _____
- ☐ Xeljanz Dates of therapy: _____
- ☐ Other Drug name: _____ Dates of therapy: _____

C. Has the patient had a negative TB test result in the past 12 months?

- ☐ Yes Date: _____
- ☐ No, rationale for use: _____

D. Will the patient be receiving other biologic therapy in combination with Kineret?

☐ No ☐ Yes, rationale for use: _____

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 09/2017
Last reviewed 09/2018