

US Family Health Plan Prior Authorization Request Form for Kineret (Anakinra)

5586



This Form applies to the US Family Health Plan Mail Order Pharmacy and the US Family Health Plan Retail Pharmacy programs. This form must be completed and signed by the prescriber.

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|-------------------|---|---------------|---|
| MAIL ORDER | If the prescription is to be filled through the USFHP Mail Order Pharmacy, check here <input type="checkbox"/> | RETAIL | If the prescription is to be filled at a retail pharmacy, check here <input type="checkbox"/> |
| | <ul style="list-style-type: none"> The completed form and the prescription may be faxed to 1-617-562-5296 OR The patient may attach the completed form to the prescription and mail it to: Attn: Pharmacy, 77 Warren Street, Brighton, MA 02135 | | <ul style="list-style-type: none"> The provider may call: 1-877-880-7007 <li style="margin-left: 40px;">OR The completed form may be faxed to 1-617-562-5296 |

Drug for which Prior Authorization is requested: **Kineret (anakinra)**

Step 1 Please complete patient and physician information (Please Print)

| | |
|---------------------|-----------------------|
| Patient Name: _____ | Physician Name: _____ |
| Address: _____ | Address: _____ |
| Sponsor ID# _____ | Phone #: _____ |
| Date of Birth _____ | Secure Fax #: _____ |

Step 2 Please complete the clinical assessment:

| | | |
|---|--|---|
| 1. Is this a continuation of therapy with Kineret? | <input type="checkbox"/> Yes Please sign and date. See for quantity limits below. | <input type="checkbox"/> No Please proceed to Question 2 |
| 2. Is the patient at least 18 years of age? | <input type="checkbox"/> Yes Please proceed to Question 3 | <input type="checkbox"/> No Coverage not approved |
| 3. Is anakinra being prescribed for the treatment of moderately to severely active rheumatoid arthritis? | <input type="checkbox"/> Yes Please proceed to Question 4 | <input type="checkbox"/> No Coverage not approved |
| 4. Will the patient be receiving Humira (adalimumab), Enbrel (etanercept) or Remicade (infliximab) in combination with Kineret? | <input type="checkbox"/> Yes Coverage not approved | <input type="checkbox"/> No Please proceed to Question 5 |
| 5. Has the patient had an inadequate response to at least one disease-modifying anti-rheumatic drug (DMARD)? | <input type="checkbox"/> Yes Please sign and date. See for quantity limits below. | <input type="checkbox"/> No Coverage not approved |

Quantity Limits: limited to a 4 week supply in retail, and an 8 week supply in mail order.

Step 3 I certify the above is true to the best of my knowledge. Please sign and date.

| | |
|----------------------|------|
| Prescriber Signature | Date |
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