Kineret (Anakinra)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	**DURATION OF THERAPY** (SPECIFY DATES):	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Moderate to severely active rheumatoid arthritis (RA) ☐ Systemic juvenile Idiopathic arthritis (sJIA)/Adult-onset Still's Disease ☐ Hidradenitis suppurativa ☐ Other Diagnosis_____ICD-10 Code(s):_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

For diagnosis of RA/sJIA, answer the following:
Is Kineret being prescribed by a rheumatologist? ☐ Yes ☐ No

Is the patient on concurrent treatment with another biologic response modifier (e.g., Rituxan, Orencia, Remicade, Humira, Enbrel, Simponi, Cimzia, Actemra, etc.)? ☐ Yes ☐ No

For moderately to severely active rheumatoid arthritis (RA), also answer the following:
Has the patient had a trial of methotrexate or another oral non-biologic disease modifying anti-rheumatic agent (DMARD) such as Imuran, Ridaura, Plaquenil, sulfasalazine or Arava? ☐ Yes ☐ No

Is the patient unable to take the prerequisite non-biologic DMARD due to chronic liver disease (such as chronic hepatitis, fatty liver, nonalcoholic steatohepatitis/NASH or elevated liver enzymes)? ☐ Yes ☐ No

Has the patient tried and failed at least a three-month trial of Enbrel? ☐ Yes ☐ No
Please provide supporting chart notes.

Has the patient tried and failed at least a three-month trial of Humira? ☐ Yes ☐ No
Please provide supporting chart notes.

For systemic onset juvenile idiopathic arthritis (sJIA) (including Adult-onset Still's disease), also answer the following:
Is the patient 2 years or older? ☐ Yes ☐ No
Is the prescriber a Rheumatologist? ☐ Yes ☐ No
Has patient's fever and/or arthritis persisted despite a trial of a NSAID? ☐ Yes ☐ No
Has the patient tried and failed at least a three-month trial of Enbrel? ☐ Yes ☐ No
Please provide supporting chart notes.
Has the patient tried and failed at least a three-month trial of Humira? ☐ Yes ☐ No
Please provide supporting chart notes.

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For diagnosis of hidradenitis suppurativa, answer the following:

Is the prescriber a dermatologist? □ **Yes** □ **No**

Is the disease severity Hurley stage II or III HS? □ **Yes** □ **No** ***Please provide documentation.***

Has the patient failed a course of Humira(adalimumab)? □ **Yes** □ **No** ***Please provide dates of service.***

Reauthorization:

If this is a reauthorization request, answer the following:

Does the patient continue to have a positive clinical response and is remission of disease maintained with continued use?* □ **Yes** □ **No**

Please provide supporting chart notes.

Is the prescriber a rheumatologist? □ **Yes** □ **No**

Is the prescriber a dermatologist? □ **Yes** □ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.
4801 E. Washington Street, Phoenix, AZ 85034
Phone: 877-228-7909