



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](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:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.





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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:
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2. LIST DIAGNOSES: **ICD-10:**

<input type="checkbox"/> Moderate to severely active rheumatoid arthritis (RA) <input type="checkbox"/> Systemic juvenile Idiopathic arthritis (sJIA) <input type="checkbox"/> Hidradenitis suppurativa <input type="checkbox"/> Other Diagnosis _____ ICD-10 Code(s): _____	
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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.*

Has the patient been treated with, and had an inadequate response to Remicade and/or Orencia? Yes No
**Please provide supporting chart notes.*

For systemic onset juvenile idiopathic arthritis (sJIA), also answer the following:
 Has the patient had systemic onset juvenile idiopathic arthritis (sJIA) for longer than six (6) months?* Yes No
**Please provide supporting chart notes.*

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





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Has the patient tried and failed at least a three-month trial of Humira? Yes No

**Please provide supporting chart notes.*

Select if the patient has any of the following:*

- Disease-related fever
- Most recent erythrocyte sedimentation rate (ESR) greater than 20
- Most recent C-reactive protein (CRP) greater than 20 mg/L

**Please provide documentation.*

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:** _____

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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

