

KINERET (anakinra)

SPECIALTY PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Patient Information	
Name:	Member ID #:
Group Name:	Date of Birth:
Diagnosis:	Diagnosis Code:

Provider Information	
Prescriber's Name:	Prescriber's DEA #:
Phone:	Fax:
Office Address:	

Complete and review information, sign and date. Fax signed form to Caremark Specialty's prior authorization department at 1-866-249-6155. The Caremark fax machine is located in a secure location as required by HIPAA regulations. On behalf of the member's health plan, Caremark assists in the administration of the prior authorization program. Caremark is an independent company that administers prescription drug benefits.

Providers may call Caremark at 1-866-814-5506 with any questions concerning prior authorization procedures. For questions related to the patient's eligibility, drug copay or delivery, providers and members should call Caremark Specialty Customer Care at 1-866-513-5214 with any questions. Members may also call their health plan at the number indicated on their Member ID cards.

Please check or circle the appropriate answer for each applicable question (Y for Yes, N for No).

1. What drug is being prescribed? Kineret
2. Is prescribed drug being used as a single Biologic Response Modifier (e.g., Enbrel, Humira, Kineret, Orencia, Remicade, Rituxan)? Y N
3. What is the diagnosis? Adult Rheumatoid Arthritis Juvenile Rheumatoid Arthritis
 Adult Still's Disease Angiogenesis inhibition in IL-1 expressing cancers
 Other (specify): _____
4. Does patient have other active infection (chronic or localized)? Y N
5. Is CrCl less than 30 mL/min? Y N
[If answer is no, skip to question 7.] Y N
6. Is Kineret dose 100 mg QOD? Y N
7. If 100 mg is not prescribed, will dose be changed to 100mg QOD? Y N
8. Is patient currently on therapy with the Biologic Response Modifier being prescribed Y N

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(Enbrel, Enbrel, Humira, Kineret, Orencia, Remicade or Rituxan)?

[If the answer is yes, skip to question 13.]

9. Has patient tried or had an insufficient response to synthetic Disease Modifying Anti-Rheumatic Drug (DMARD)? Y N

If no, please document the clinical reason for not trying a MARD:

10. If yes, please document the DMARD and the length of therapy that the patient has tried or had insufficient response to:
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11. Was patient compliant with therapy? Y N

12. Has dose/route been optimized without adequate response? Y N

13. Is the prescribed medication the same as the Biologic Response Modifier (BRM) that the patient is currently on? Y N

If the prescribed medication is the same as the BRM that the patient is currently on, has the patient's RA improved? Y N

If no, what is the reason for the lack of improvement? _____

If the prescribed medication is not the same as the BRM that the patient is currently on, please document current BRM and length of therapy. _____

Will current BRM be discontinued? Y N

Comments:

I affirm that the information given on this form is accurate as of this date.

Prescriber (or Authorized) Signature and Date::