

Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Kineret (anakinra) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorization: 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Kineret (anakinra)**. Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: <u>1-866-331-2104</u>]. If you have any questions or concerns, please call <u>1-866-331-2103</u>. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at: http://pithelp.appl.kp.org/MAS/formulary.html**

1 – Patient Information			
Patient Name:	Kaiser Medical ID#:	Date of Birth:	
2 – Provider Information			
Provider Name:	Specialty:	Provider NPI:	
Provider Address:			
Provider Phone #:	Provider Fax #:		
Please check the boxes that apply: □ Initial Request □ Continuation of Therap	y Request		
3 – Pharmacy Information			
Pharmacy Name:	Pharmacy NPI:		
Pharmacy Phone #	Pharmacy Fax #:		
4 – Drug Therapy Requested			
Drug 1: Name/Strength/Formulation:			
Drug 2: Name/Strength/Formulation:			

5- Diagnosis/Clinical Criteria

1.	 Is the medication is being used for Cryopyrin-Associated Periodic Syndromes (CAPS) or treatment of Neonatal-Onset Multisystem Inflammatory Disease? □ No □ Yes 		
<u>If</u> #	1 does not apply, please fill out the rest of this form		
2.	Does the member have diagnosis of one of the following? AND □ Rheumatoid Arthritis (RA)		
	□ Juvenile Idiopathic Arthritis (JIA)		
	□ Other:		
3.	Was there therapeutic failure on oral methotrexate? AND □ No □ Yes		
4.	Was there therapeutic failure to one of the preferred agents? (e.g. Enbrel, Humira) AND \Box No \Box Yes		
5.	 If this is being used for Rheumatoid arthritis (RA): a. Did the patient try and fail or have a contraindication, or adverse reaction to methotrexate and at least one other DMARD (sulfasalazine, hydroxychloroquine, minocycline)? □ No □ Yes 		
	6 – Provider Sign-Off		
Additio	nal Information – Please provide any additional information that should be taken into consideration.		
l cert	y that the information provided is accurate. Supporting documentation is available for State audits.		
	der Signature: Date:		
infor distri	Note: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The ation is private and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, ution or taking of any action in reliance on the contents of this telecopied information is strictly prohibited. Please notify sender if document was not ed for receipt by your facility		