Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Anakinra (Kineret) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **anakinra (Kineret).** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Is the prescriber a rheumatologist or dermatologist? □ No □ Yes

If consulted with a specialist, specialist name and specialty: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5–Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
□ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

1. Member has a diagnosis of moderate to severe rheumatoid arthritis
   □ No □ Yes

2. **AND** member has a documented inadequate response or no response to at least 3- month trial of 1 non-biologic DMARD AND 1 biologic DMARD
   □ No □ Yes

3. **AND** member has documented failure, contraindication, or intolerance to adalimumab biosimilars (Amjevita preferred) or Humira, Enbrel and Xeljanz
   □ No □ Yes

4. **AND** member has documented inadequate response, contraindication, or inability to tolerate at least one of the following:
   a. Actemra (tocilizumab)
   b. Orencia (abatacept)
   □ No □ Yes

OR

1. Kineret is being prescribed for a patient ≥2 years old for treatment of systemic-onset juvenile idiopathic arthritis (JIA) who have failure, intolerance or contraindications to NSAIDs and glucocorticoids (NOT covered for other subtypes of JIA)?
   □ No □ Yes

OR

1. Kineret is being prescribed for Neonatal-onset multisystem inflammatory disease (NOMID)
   □ No □ Yes

2. **AND** patient is not receiving Kineret in combination with any of the following: biologic DMARD, Janus kinase inhibitor, phosphodiesterase 4 (PDE4) inhibitor
   □ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below:

1. Member has documented a clinically significant benefit from medication,
   □ No □ Yes

2. **AND** specialist follow-up occurred in past 12 months since last review,
   □ No □ Yes

3. **AND** member is not receiving Kineret in combination with any of the following: biologic DMARD, Janus kinase inhibitor, phosphodiesterase 4 (PDE4) inhibitor
   □ No □ Yes

6 – Prescriber Sign-Off

Additional Information

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**
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