pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

KINERET (anakinra) [non-preferred] PRIOR AUTHORIZATION FORM

Cytokine and CAM Antagonists and **Quantity Limits/Daily Dose Limits** prior authorization guidelines are accessible on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/State/Zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Product requested: ☐Kineret 100 mg/0.67 ml syringe ☐Kineret _____

Dose/directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:	Dx code (*required*):	

INITIAL request – complete questions applicable to beneficiary's diagnosis

1. ***All diagnoses***: Check all that apply to the beneficiary and *submit documentation for each*.
   ☐vaccinated for hepatitis B ☐screened for hepatitis B (surface antigen & core antibody) ☐has been using Kineret in the past 90 days
   ☐screened for tuberculosis ☐up-to-date with all age-appropriate immunizations

2. ***All diagnoses***: Does the beneficiary have baseline results of the following lab tests? *Check all that apply.*
   ☐CBC with differential ☐serum creatinine
   ☐Yes ☐No *Submit documentation of results.*

3. ***Neonatal-onset multisystem inflammatory disease (NOMID)*** and ***other periodic fever syndromes (PFS)*** *or* ***systemic juvenile idiopathic arthritis (sJIA):*** Submit form & requested documentation to Pharmacy Services.

4. ***Rheumatoid arthritis:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of at least 3 months of treatment with methotrexate or another DMARD?
   ☐Yes ☐No *Submit documentation of all medications tried and outcomes.*

5. ***Rheumatoid arthritis*:** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred agents? *Check all that apply.*
   ☐Humira ☐Xeljanz
   ☐Yes ☐No *Submit documentation of all medications tried and outcomes.*

6. ***All other diagnoses:*** Submit documentation supporting the use of Kineret for the beneficiary's diagnosis & other treatments tried.

RENEWAL request

1. Since starting Kineret, did the beneficiary experience a positive clinical response and/or improved level of functioning?
   ☐Yes ☐No *Submit documentation of clinical response.*

2. Does the beneficiary have recent results (since starting Kineret) of the following lab tests? *Check all that apply.*
   ☐CBC with differential ☐serum creatinine
   ☐Yes ☐No *Submit documentation of results.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: