



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Kineret® (anakinra)

Phone: 215-991-4300 Fax back to: 866-240-3712

HEALTH PARTNERS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please print clearly.**

<p>Patient Name:</p> <p>Member Number:</p> <p>Date of Birth:</p> <p>Group Number:</p> <p>Address:</p> <p>City, State, Zip:</p>	<p>Physician Name:</p> <p>Fax: Phone:</p> <p>Office Contact:</p> <p>NPI: State Lic. Id:</p> <p>Address:</p> <p>City, State, Zip:</p>
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Drug Name: Expedited/Urgent

Directions:

Please answer the following questions and sign below:
<p>Q1. What is the requested duration of therapy?</p> <p style="padding-left: 40px;">6 months or less More than 6 months</p>
<p>Q2. What is the prescriber's specialty?</p> <p style="padding-left: 40px;">Rheumatologist Other</p> <p style="padding-left: 40px;">Q3. If Other, please specify:</p>
<p>Q4. What is the patient's age?</p> <p style="padding-left: 40px;">Less than 18 years old</p> <p style="padding-left: 40px;">18 years or older</p>
<p>Q5. What is the patient's diagnosis?</p> <p style="padding-left: 40px;">Moderate to severe active Rheumatoid Arthritis</p> <p style="padding-left: 40px;">Other</p> <p style="padding-left: 40px;">Q6. If Other, please specify:</p>
<p>Q7. Has the patient failed or had an inadequate response to the trial of at least one DMARD OR is intolerant to DMARDs. [e.g., Imuran® (azathioprine), Ridaura® (oral gold), Plaquenil® (hydroxychloroquine), Cuprimine® (D-penicillamine), Azulfidine® (sulfasalazine), methotrexate?</p> <p style="padding-left: 40px;">Yes No</p>
<p>Q8. The patient has a history of failure or contraindication to Tumor Necrosis Factor (TNF) blocking agents (ex: Enbrel®)?</p> <p style="padding-left: 40px;">Yes No</p>
<p>Q9. The patient is a candidate for TNF blocking agent (Enbrel®), but is unable to be treated due to product unavailability?</p> <p style="padding-left: 40px;">Yes No</p>
<p>Q10. If the patient was receiving a Tumor Necrosis Factor (TNF) blocking agent (e.g., Enbrel®, Remicade®) will it be discontinued prior to Kineret therapy?</p>



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Patient Name:

Physician Name:

Yes	No	N/A
Q11. Has the patient failed a course of therapy with either Enbrel or Humira?		
Yes	No	
Q12. Deliver to:		
Physician's Office	Home Delivery	
Q13. Delivery date needed:		

Physician Signature

Date

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