PRIOR AUTHORIZATION REQUEST
Kineret

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. ☐ Yes ☐ No Will the requested medication be used in combination with a BIOLOGIC or with a targeted synthetic disease-modifying antirheumatic drug (DMARD) used for an inflammatory condition?
   - ☐ BIOLOGICs for an inflammatory condition
   - ☐ Conventional synthetic DMARD - **Please Proceed to question 2**
   - ☐ No, the requested medication will NOT be used in combination with another BIOLOGIC or Targeted Synthetic disease-modifying antirheumatic drug (DMARD) - **Please Proceed to question 2**
2. ☐ Yes ☐ No Is the patient currently receiving Kineret?
3. What is the patient's diagnosis?
   - ☐ Rheumatoid arthritis - **Please answer questions 4, 5 & 9**
   - ☐ Systemic juvenile idiopathic arthritis (SJIA) - **Please answer questions 6, 8, 9, 11 & 13**
   - ☐ Still's Disease - **Please answer questions 9 & 13 - 16**
   - ☐ Cryopyrin-Associated Periodic Syndromes (CAPS) - **Please answer questions 7, 10 & 12**
   - ☐ COVID-19 (Coronavirus Disease 2019) Note: This includes requests for cytokine release syndrome associated with COVID-19. - **Please answer question 17**
   - ☐ Osteoarthritis (OA), symptomatic
   - ☐ Lupus arthritis
   - ☐ Ankylosing spondylitis
   - ☐ All other indications – Please Specify _____
4. ☐ Yes ☐ No Has the patient had a response, as determined by the prescriber?
5. ☐ Yes ☐ No Has the patient had a 3 month trial of a biologic disease-modifying antirheumatic drug (DMARD) for this condition OR was intolerant to one of these medications?
6. ☐ Yes ☐ No Has the patient tried one other systemic agent for this condition?
7. ☐ Yes ☐ No Is Kineret being used for the treatment of Familial Cold Autoinflammatory Syndrome [FCAS], Muckle-Wells Syndrome [MWS], Neonatal Onset Multisystem Inflammatory

If you have any questions, call: 800-753-2851

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Disease [NOMID] and/or chronic infantile neurological cutaneous and articular [CINCA] syndrome)?

8. □ Yes □ No Does the patient have at least moderate to severe active systemic features of this condition OR does the patient have active systemic features with an active joint count of one joint or greater, according to the prescriber?
9. □ Yes □ No Is Kineret being prescribed by or in consultation with a rheumatologist?
10. □ Yes □ No Is Kineret being prescribed by or in consultation with a rheumatologist, geneticist, or dermatologist?
11. □ Yes □ No Does the patient have active systemic features with concerns of progression to macrophage activation syndrome (MAS), as determined by the prescriber?
12. □ Yes □ No Has the patient had a response, as determined by the prescriber?
13. □ Yes □ No Has the patient responded, as determined by the prescriber?
14. □ Yes □ No Has the patient tried a corticosteroid AND has had an inadequate response to one conventional synthetic DMARD (disease modifying antirheumatic drug) such as methotrexate or a previous trial of a biologic (for example, Actemra IV, Arcalyst, Ilaris) given for at least 2 months or was intolerant to a conventional synthetic DMARD?
15. □ Yes □ No Does the patient have active systemic features with concerns of progression to macrophage activation syndrome, as determined by the prescriber?
16. □ Yes □ No Does the patient have at least moderate to severe active systemic features of this condition, according to the prescriber? Note: Examples of moderate to severe active systemic features include fever, rash, lymphadenopathy, hepatomegaly, splenomegaly, and serositis.
17. Please provide the patient's diagnosis or indication, prescribed dose, frequency and route of administration, any other medications previously tried with duration of trial, and prescriber's or consultant's specialty. If the patient is already on this medication, when was it started?

_____

Please document the diagnoses, symptoms, and/or any other information important to this review:

_____

_____

SECTION B Physician Signature

_____

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a

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covered Health Plan Benefit and medically necessary with prior

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