maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Kineret

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests.

1	Is the patient currently using other biologics or targeted disease modifying antirheumatic drugs (DMARDS) such as adalimumab SC products (Humira, biosimilars), Cimzia, etanercept SC products (Enbrel, biosimilars), infliximab IV products (Remicade, biosimilars), Actemra (IV or SC), Simponi SC, Simponi Aria (IV), Orencia (IV or SC), rituximab IV products (Rituxan, biosimilars), Ilaris, Kevzara, Stelara (SC or IV), Siliq, Cosentyx, Taltz, Ilumya, Skyrizi, Tremfya, Entyvio OR Targeted synthetic DMARD (such as Otezla, Olumiant, Rinvoq, or Xeljanz/XR)? [If yes, no further questions.]	Yes	No
2	Is the patient currently taking the requested medication? [If no, skip to question 8.]	Yes	No
3	Has the patient been receiving samples for Kineret?	Yes	No

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[If yes, skip to question 8.]

4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 8.]	Yes	No

6 What is the patient's diagnosis?

[] Cryopyrin-Associated Periodic Syndromes (CAPS) (If checked, go to 9)

[] Deficiency of Interleukin-1 Receptor Antagonist (DIRA) (If checked, go to 10)

[] Rheumatoid arthritis (RA) (If checked, go to 11)

[] Systemic juvenile idiopathic arthritis (SJIA) (If checked, go to 11)

[] Still's Disease (If checked, go to 11)

[] COVID-19 (Coronavirus Disease 2019) [NOTE: This includes requests for cytokine release syndrome associated with COVID-19.] (If checked, no further questions)

[] Ankylosing Spondylitis (If checked, no further questions)

[] Lupus Arthritis (If checked, no further questions)

[] Osteoarthritis (OA) (If checked, no further questions)

[] Other (If checked, no further questions)

7	Has documentation been submitted to confirm that the patient has experienced a clinically significant response, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No

8 What is the patient's diagnosis?

[] Cryopyrin-Associated Periodic Syndromes (CAPS) (If checked, go to 13)

[] Deficiency of Interleukin-1 Receptor Antagonist (DIRA) (If checked, go to 20)

[] Rheumatoid arthritis (RA) (If checked, go to 26)

[] Systemic juvenile idiopathic arthritis (SJIA) (If checked, go to 22)

[] Still's Disease (If checked, go to 34)

[] COVID-19 (Coronavirus Disease 2019) [NOTE: This includes requests for cytokine release syndrome associated with COVID-19.] (If checked, no further questions)

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	[] Ankylosing Spondylitis (If checked, no further questions)		
	[] Lupus Arthritis (If checked, no further questions)		
	[] Osteoarthritis (OA) (If checked, no further questions)		
	[] Other (If checked, no further questions)		
9	Is the requested medication prescribed by, or in consultation with a rheumatologist, geneticist, or a dermatologist? [If yes, skip to question 12.] [If no, no further questions.]	Yes	No
10	Is the requested medication prescribed by, or in consultation with a rheumatologist, geneticist, or a dermatologist, or a physician specializing in the treatment of autoinflammatory disorders? [If yes, skip to question 12.] [If no, no further questions.]	Yes	No
11	Is the requested medication prescribed by, or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
12	Has documentation been submitted to confirm that the patient has experienced a clinically significant response, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
13	Does the patient have a documented diagnosis of a cryopyrin associated periodic syndrome? [NOTE: This may include neonatal onset multisystem inflammatory disease (NOMID), familial cold autoinflammatory syndrome (FCAS), Muckle-Wells Syndrome (MWS), and/or chronic infantile neurological cutaneous and articular (CINCA) syndrome.] [If no, no further questions.]	Yes	No
14	Has the patient's diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPs) been confirmed by a positive genetic test for NALP3, CIASI, or NLRP3 mutation? [If no, no further questions.]	Yes	No
15	Does the patient have elevated inflammatory markers (C-reactive protein [CRP] and serum amyloid A)? [If no, no further questions.]	Yes	No
16	Does the patient have at least TWO of six typical Cryopyrin-Associated Periodic Syndromes (CAPs) manifestations: A) Urticaria-like rash, B) Cold-triggered episodes, C) Sensorineural hearing loss, D) Musculoskeletal symptoms, E) Chronic aseptic meningitis, OR F) Skeletal abnormalities? [If no, no further questions.]	Yes	No
17	Does the patient have functional impairment limiting the activities of daily living? [If no, no further questions.]	Yes	No
18	Does the dose of the requested medication exceed FDA approved label dosing for the indication?	Yes	No

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	[If yes, no further questions.]		
19	Is the requested medication prescribed by or in consultation with a rheumatologist, geneticist, or a dermatologist? [No further questions.]	Yes	No
20	Has genetic testing confirmed a mutation in the ILIRN gene? [If no, no further questions.]	Yes	No
21	Is the requested medication prescribed by or in consultation with a rheumatologist, geneticist, dermatologist, or a physician specializing in the treatment of autoinflammatory disorders? [No further questions.]	Yes	No
22	Does the patient have a documented diagnosis of systemic juvenile idiopathic arthritis (SJIA)? [If no, no further questions.]	Yes	No
23	Has documentation been submitted to confirm that the patient has synovitis in at least ONE joint? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
24	Has the patient tried TWO other systemic prescription strength agents for this condition for at least 3 months? [NOTE: Examples of systemic prescription strength agents include a corticosteroid (oral, intravenous); a conventional synthetic disease-modifying antirheumatic drug (DMARD such as methotrexate, leflunomide, sulfasalazine).] [If yes, skip to question 30.]	Yes	No
25	Has documentation been submitted to confirm that the patient has an intolerance to at least TWO systemic prescription strength agents? ACTION REQUIRED: Submit supporting documentation. [NOTE: Examples of systemic prescription strength agents include a corticosteroid (oral, intravenous); a conventional synthetic disease-modifying antirheumatic drug (DMARD such as methotrexate, leflunomide, sulfasalazine).] [If yes, skip to question 30.] [If no, no further questions.]	Yes	No
26	Does the patient have a documented diagnosis of moderately to severely active rheumatoid arthritis? [If no, no further questions.]	Yes	No
27	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
28	Has the patient tried TWO conventional synthetic disease-modifying antirheumatic drug (DMARD) for at least 3 months? [NOTE: Examples of conventional synthetic DMARDs include methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine.] [If yes, skip to question 30.]	Yes	No
29	Has documentation been submitted to confirm that the patient has an intolerance to at least TWO conventional synthetic disease-modifying antirheumatic drugs (DMARDs)?	Yes	No

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	ACTION REQUIRED: Submit supporting documentation. [NOTE: Examples of conventional synthetic DMARDs include methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine.] [If no, no further questions.]		
30	Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or failed treatment for at least 3 months with preferred TNF inhibitors: Enbrel (etanercept) and an adalimumab product (Hadlima, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
31	Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or failed treatment for at least 3 months with preferred JAK inhibitor: Xeljanz? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
32	Does the dose of the requested medication exceed FDA approved label dosing for the indication? [If yes, no further questions.]	Yes	No
33	Is the requested medication being prescribed by, or in consultation with a rheumatologist? [No further questions.]	Yes	No
34	Does the patient have a documented diagnosis of still's disease? [If no, no further questions.]	Yes	No
35	Has the patient had a trial and failure, contraindication, or intolerance to: corticosteroid for at least 3 months? [If no, no further questions.]	Yes	No
36	Has the patient had a trial and failure, contraindication, or intolerance to conventional synthetic disease modifying antirheumatic drugs (DMARDs) for at least 3 months? [If no, no further questions.]	Yes	No
37	Has the patient had a trial and failure, contraindication, or intolerance to nonsteroidal anti-inflammatory drug for at least 3 months? [If no, no further questions.]	Yes	No
38	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.] [If yes, skip to question 40.]	Yes	No
39	Does the patient have active systemic features with concerns of progression to macrophage activation syndrome, as determined by the prescriber? [If no, no further questions.]	Yes	No
40	Is the requested medication prescribed by, or in consultation with a rheumatologist?	Yes	No

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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: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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