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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is the request for an INITIAL or a CONTINUATION of therapy? [] Initial (If checked, go to 8) [] Continuation (If checked, go to 2)		
2	Will the requested medication be used in combination with other biologics? [Note: Examples of biologics include but not limited to adalimumab SC products (for example, Humira, biosimilars), Actemra (IV or SC), Cimzia, Cosentyx, an	Yes	No

PRIOR AUTHORIZATION REQUEST

	etanercept SC product (for example, Enbrel, biosimilars), Ilumya, Skyrizi, Kevzara, Kineret, Orencia (IV or SC), an infliximab IV products (Remicade, biosimilars), a rituximab IV products (for example, Rituxan, biosimilars), Siliq, Stelara (IV or SC), Taltz, Tremfya, Entyvio, or Simponi (Aria or SC).] [If yes, no further questions.]		
3	Is the patient currently receiving the requested medication? [If no, skip to question 8.]	Yes	No
4	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 8.]	Yes	No
5	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 8.]	Yes	No
6	Has the patient been established on therapy for AT LEAST 3 months? [If no, skip to question 8.]	Yes	No
7	Has documentation been submitted to confirm that the patient has had a clinically significant response, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
8	Will the requested medication be used in combination with other biologics? [Note: Examples of biologics include but not limited to adalimumab SC products (for example, Humira, biosimilars), Actemra (IV or SC), Cimzia, Cosentyx, an etanercept SC product (for example, Enbrel, biosimilars), Ilumya, Skyrizi, Kevzara, Kineret, Orencia (IV or SC), an infliximab IV products (Remicade, biosimilars), a rituximab IV products (for example, Rituxan, biosimilars), Siliq, Stelara (IV or SC), Taltz, Tremfya, Entyvio, or Simponi (Aria or SC).] [If yes, no further questions.]	Yes	No
9	What is the patient's diagnosis? [] Cryopyrin-Associated Periodic Syndromes (CAPS) (If checked, go to 10) [] Deficiency of Interleukin-1 Receptor Antagonist (DIRA) (If checked, go to 17) [] Rheumatoid arthritis (RA) (If checked, go to 20) [] Still's Disease (If checked, go to 28) [] COVID-19 (Coronavirus Disease 2019) [NOTE: This includes requests for cytokine release syndrome associated with COVID-19.] (If checked, no further		

PRIOR AUTHORIZATION REQUEST

	questions) [] Other (If checked, no further questions)		
10	Does the patient have a documented diagnosis of a cryopyrin associated periodic syndrome? ACTION REQUIRED: Submit supporting documentation. [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
11	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
12	Does the patient have elevated inflammatory markers (C-reactive protein [CRP] and serum amyloid A)? [If no, no further questions.]	Yes	No
13	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
14	Does the patient have functional impairment limiting the activities of daily living? [If no, no further questions.]	Yes	No
15	Is the requested medication being prescribed by or in consultation with a rheumatologist, geneticist, or a dermatologist? [If no, no further questions.]	Yes	No
16	Does the dose of the requested medication exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Dosing: 1-2 mg/kg daily with a maximum dose of 8 mg/kg daily.] [No further questions.]	Yes	No
17	Has genetic testing confirmed a mutation in the *ILIRN* gene? [If no, no further questions.]	Yes	No
18	Is the requested medication being prescribed by or in consultation with a rheumatologist, geneticist, dermatologist, or a physician specializing in the treatment of autoinflammatory disorders? [If no, no further questions.]	Yes	No
19	Does the dose of the requested medication exceed the Food and Drug Administration (FDA) approved label dosing for the indication?	Yes	No

PRIOR AUTHORIZATION REQUEST

	[Dosing: 1-2 mg/kg daily with a maximum dose of 8 mg/kg daily.] [No further questions.]		
20	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
21	Does the patient have a documented diagnosis of moderately to severely active rheumatoid arthritis? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
22	Has the patient tried TWO conventional synthetic disease-modifying antirheumatic drugs (DMARDs) 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 24.]	Yes	No
23	Has documentation been submitted to confirm that the patient has an intolerance to at least TWO conventional synthetic disease-modifying antirheumatic drugs (DMARDs)? 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.]	Yes	No
24	Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or failed treatment for at least 3 months with a preferred TNF inhibitor: an adalimumab product (Hadlima, Yusimry, or adalimumab- adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
25	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
26	Is the requested medication being prescribed by, or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
27	Does the dose of the requested medication exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Dose: 100 mg daily.] [No further questions.]	Yes	No
28	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
29	Does the patient have a documented diagnosis of still's disease? ACTION REQUIRED: Submit supporting documentation.	Yes	No

PRIOR AUTHORIZATION REQUEST

	[If no, no further questions.]		
30	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
31	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
32	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
33	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 35.]	Yes	No
34	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
35	Is the requested medication being prescribed by, or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
36	Does the dose of the requested medication exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Dose: 100 mg daily.]	Yes	No

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

SECTION B: Physician Signature

If you have any questions, call: 1-888-258-8250

Version 04.2026

PRIOR AUTHORIZATION REQUEST

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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