



Prior Authorization Request

Date of Request _____

Kineret **Kineret (Anakinra) is a human Interleuken-1 receptor antagonist used for the treatment of moderate to severe rheumatoid arthritis.**
 Patient must be \geq 18 years of age and failed (or intolerant to) a trial of methotrexate.
 Must be prescribed by a rheumatologist and NOT used in conjunction with Enbrel, Humira, or Remicade.

[3 months]

Reevaluation- symptom improvement as indicated by two of the following:

- Reduction in ESR or C-reactive protein level,
- Improvement in functional status,
- Improvement in radiographic examination of involved joints,
- Reduction in duration of morning stiffness or fatigue.

[12 months]

Enrollment / Cardholder ID _____ **Gender** (Circle)
 Group / Plan _____ **Male Female**
 Birth date _____ **AGE:** _____ **Weight (kg):** _____
 Address: _____
 City State Zip _____

Practitioner Information

Name _____
 Agent / Contact Name _____
 Specialty _____
 Office / Clinic Name _____
 Address _____
 City State Zip _____

Phone () - _____
 Fax () - _____
 ID Number _____
 Email _____ @ _____

Previous use?	Y	N
Use with Enbrel, Humira, or Remicade?	Y	N

Requested Drug / Pharmaceutical

Kineret (Anakinra)

Strength / Dose

Condition / Diagnosis Related - Reason for Request

Therapy Start Date

Duration of Therapy (Expected)

Type of Request (Circle)
One-Time On-Going

Clinical Drug / Lab History Pertinent to Request

Labs: Baseline / Ongoing

Formulary Alternative(s) Attempted YES NO (Circle)
 Please List:

Contact Pharmacy? Y N
Pharmacy Phone Number

Practitioner Signature