Prior Authorization Request Form for
anakinra **(Kineret)**

JOHNS HOPKINS
HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: ____________________ Physician Name: ____________________
Address: ____________________ Address: ____________________
____________________ ____________________
Sponsor ID # ____________________ Phone #: ____________________
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

Question	Yes	No
1. Is this a pediatric patient (less than 18 years old) with a diagnosis of Neonatal Onset Multisystem Inflammatory Disease (NOMID), Cryopyrin-Associated Periodic Syndrome (CAPS) or systemic juvenile idiopathic arthritis (sJIA)?	☐ Yes proceed to question **8**	☐ No proceed to question **2**
2. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	☐ Yes proceed to question **3**	☐ No proceed to question **5**
3. Has the patient had an inadequate response to Humira?	☐ Yes proceed to question **6**	☐ No proceed to question **4**
4. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes proceed to question **6**	☐ No **STOP** **Coverage not approved**
5. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Is this an adult patient (18 years of age or older) with a diagnosis of moderate to severe active rheumatoid arthritis?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Has the patient failed 1 or more disease modifying antirheumatic drugs (DMARDs)?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**

8. Does the patient have a negative TB test result in the past 12 months (or is TB adequately managed)?	☐ Yes proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Will the patient be receiving other targeted immunomodulatory biologics with Kineret, including but not limited to the following: Actemra, Cimzia, Cosentyx, Enbrel, Humira, Ilumya, Kevzara, Olumiant, Orencia, Otezla, Remicade, Rituxan, Siliq, Simponi, Stelara, Taltz, Tremfya or Xeljanz/Xeljanz XR?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature ____________________ Date __________

[24 April 2019]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: