

PREAUTHORIZATION FORM
Kineret™
(Anakinra)

Therapeutic use: Reduction in signs and symptoms of moderately to severely active rheumatoid arthritis

Quantity Limit: 100 mg injected subcutaneously daily

Authorization Period: 12 months

Patient's name _____

Patient's ID# [][][][][][][][][][] DOB [][] / [][] / [][][][][]

ICD-9 [][][][][][][][][][] _____

Physician's name _____

Physician's Ph# ([][][][]) [][][][][] - [][][][][] Fax# [][][][] - [][][][][]

Physician's signature _____ Date signed [][] / [][] / [][][][][]

Supervising Physician's name _____ (Required if requesting provider is a nurse practitioner or physician assistant)

Please check "Yes" or "No" and respond to the following requests:			
1.	Has the patient failed treatment with Enbrel or Remicade?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	Has the patient been diagnosed with moderate to severe active RA (meeting the American College of Rheumatology criteria)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Has the patient been diagnosed with systemic juvenile idiopathic arthritis with active systemic features?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4.	Does the patient have persistent active disease and been treated for three months (less, if therapy discontinued due to complications) with three of the treatments listed below? a) Methotrexate >15mg/week b) Leflunomide 100 mg daily on days 1-3, then 10-20 mg po qd c) Hydroxychloroquine 200 mg po bid for at least three months d) Sulfasalazine 1 g po bid-tid e) Injectable gold salts >25 mg im q2-4 weeks f) Oral gold 3 mg po qd-bid g) Azathioprine > 50 mg po h) D-penicillamine >250 mg po qd i) Cyclosporine > 2.5 mg/kg/day po	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<ul style="list-style-type: none"> Concomitant use of tumor necrosis factor blocking agents is NOT recommended due to an increased risk for serious infections Therapy should not be initiated in patients with active infection or pre-existing neutropenia Use caution in patients who are immunosuppressed or have chronic infections 			

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.