Kineret (anakinra)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES):			

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Revision Date: 9/1/24

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Moderate to severely active rheumatoid arthritis (RA) ☐ Systemic juvenile Idiopathic arthritis (sJIA)/Adult-onset Still's Disease ☐ Hidradenitis suppurativa ☐ Refractory Kawasaki's Disease ☐ Deficiency of Interleukin-1 Receptor Antagonist(DIRA) ☐ Neonatal-Onset Multisystem Inflammatory Disease(NOMID) ☐ Recurrent pericarditis ☐ Other Diagnosis_____ICD-10 Code(s):_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Is the requested drug being used in conjunction with a clinical trial? ? ☐ Yes ☐ No

Is Kineret being prescribed by a rheumatologist? ☐ Yes ☐ No
Is Kineret being prescribed by a dermatologist? ☐ Yes ☐ No
Is Kineret being prescribed by a immunologist? ☐ Yes ☐ No
Is Kineret being prescribed by a cardiologist? ☐ Yes ☐ No
Is Kineret being prescribed by a pediatrician? ☐ Yes ☐ No

Is the patient on concurrent treatment with another biologic response modifier or immunomodulatory agent (e.g., Rituxan, Orencia, Remicade, Humira, Enbrel, Simponi, Cimzia, Actemra, Arcalyst etc.)? ☐ Yes ☐ No

Will the patient use drug in combination with another biologic response modifier or immunomodulatory agent? ☐ Yes ☐ No

Has the patient tried and had an inadequate response to a three month trial of the biosimilar for Humira-adalimumab-aacf? ☐ Yes ☐ No Please submit documentation.

Does patient have a absolute contraindication to the biosimilar for Humira- adalimumab-aacf? ☐ Yes ☐ No Please submit documentation.

Has the patient tried and had an inadequate response to a trial of the biosimilar for Actemra, Tyenne(tocilizumab-aazg)? ☐ Yes ☐ No Please submit documentation.

Does patient have a absolute contraindication to the biosimilar for Actemra, Tyenne(tocilizumab-aazg)? ☐ Yes ☐ No Please submit documentation.

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For moderately to severely active rheumatoid arthritis (RA), also answer the following:
Has the patient had a trial of methotrexate or another oral non-biologic disease modifying anti-rheumatic agent (DMARD) such as Imuran, Ridaura, Plaquenil, sulfasalazine or Arava? □ Yes □ No

Is the patient unable to take the prerequisite non-biologic DMARD due to chronic liver disease (such as chronic hepatitis, fatty liver, nonalcoholic steatohepatitis/NASH or elevated liver enzymes)? □ Yes □ No

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For systemic onset juvenile idiopathic arthritis (sJIA)(including Adult-onset Still's disease), also answer the following:
Is the patient 2 years or older? □ Yes □ No
Has patient's fever and/or arthritis persisted despite a trial of a NSAID? □ Yes □ No

For diagnosis of hidradenitis suppurativa, answer the following:

Is the disease severity Hurley stage II or III HS? □ Yes □ No *Please provide documentation.*

For diagnosis of refractory Kawasaki's disease, answer the following:

Is the patient currently prescribed aspirin? □ Yes □ No
Has the patient failed at least one courses of IVIG? □ Yes □ No *Please provide documentation.*
Has the patient failed treatment with at least one course of steroids? □ Yes □ No *Please provide documentation.*
Does the patient continue to have uncontrolled fevers? □ Yes □ No *Please provide documentation.*
Does the patient have the development of coronary artery aneurysm(s) □ Yes □ No *Please provide documentation.*

For diagnosis of Neonatal-Onset Multisystem Inflammatory Disease(NOMID/CINCA), answer the following:

Does patient have at least 2 of the following clinical manifestations? □ Yes □ No *Please provide documentation.*
□ NOMID rash
□ CNS involvement(papilledema, CSF pleocytosis, sensorineural hearing loss)
□ Arthropathic changes on radiograph(epiphyseal and/or patellar overgrowth)

Did patient's onset of clinical manifestations of NOMID/CINCA occur at less than or equal to 6 months of age? □ Yes □ No *Please provide documentation.*

Has patient been on a stable dose of steroids, NSAIDs, DMARDs for at least 4 weeks prior to starting Kineret? □ Yes □ No *Please provide documentation.*

Does patient have a history of malignancy? □ Yes □ No

Does patient have any other rheumatic disease or major chronic infectious/inflammatory/immunologic disease such as inflammatory bowel disease, psoriatic arthritis, spondyloarthropathy, system lupus erythrematosus(SLE)? □ Yes □ No *Please provide documentation.*

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For <u>diagnosis of Deficiency of Interleukin-1 Receptor Antagonist(DIRA),</u> answer the following:

Does patient have a lab confirmed homozygous mutations of *IL1RN* causing deficiency of interleukin-1 receptor antagonist? □ Yes □ No **Please provide documentation.*

Does patient exhibit clinical manifestations of DIRA such as diffuse pustular rash, sterile osteomyelitis, and/or periostitis with articular pain? □ Yes □ No **Please provide documentation.*

Does patient have any other rheumatic disease or major chronic infectious/inflammatory/immunologic disease such as inflammatory bowel disease, psoriatic arthritis, spondyloarthropathy, system lupus erythrematosus(SLE)? □ Yes □ No **Please provide documentation.*

Has patient had prior use with non-steroidal anti-inflammatories, methotrexate, and/or corticosteroids? □ Yes □ No **Please provide documentation.*

For diagnosis of <u>recurrent pericarditis</u>, answer the following:
Has patient had prior treatment for at least one(1) month with colchicine plus a non-steroidal anti-inflammatory or a corticosteroid? □ Yes □ No **Please provide documentation.*
Does patient have an absolute contraindication to colchicine, a non-steroidal anti-inflammatory and/or a corticosteroid? □ Yes □ No **Please provide documentation.*
Has patient had at least 3 recurrent pericarditis episodes, defined as a subsequent pericarditis episode after an asymptomatic period of at least 4 to 6 weeks? □ Yes □ No **Please provide documentation.*

Does patient have a documented pericarditis pain score ≥4 (11-point numeric rating scale [NRS])? □ Yes □ No **Please provide documentation.*

Does patient have a documented C-reactive protein ≥1 mg/dL? □ Yes □ No **Please provide documentation.*

Does patient have evidence from findings on electrocardiography and/or echocardiography of pericarditis? □ Yes □ No **Please provide documentation.*

Does patient have pericarditis secondary to TB; post-thoracic blunt trauma; myocarditis; systemic autoimmune diseases (excluding Still's disease); or neoplastic, purulent, or radiation etiologies? □ Yes □ No **Please provide documentation.*

<u>Reauthorization:</u>

If this is a reauthorization request, answer the following:

Will the patient use another biologic response modifier or immunomodulatory drug in combination with the requested drug? □ Yes □ No

<u>For diagnosis of RA / sJIA / Still's disease / Hidradenitis suppurativa,</u> answer the following:

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Does the patient continue to have a positive clinical response and is remission of disease maintained with continued use?* □ **Yes** □ **No** ***Please provide supporting chart notes.***

Is the prescriber a rheumatologist? □ **Yes** □ **No**

Is the prescriber a dermatologist? □ **Yes** □ **No**

For diagnosis of Refractory Kawasaki's Disease, answer the following:
Is the prescriber a rheumatologist? □ **Yes** □ **No**
Is the prescriber an immunologist? □ **Yes** □ **No**
Is the prescriber a pediatrician? □ **Yes** □ **No**

Does patient continue to show a decrease in their inflammatory markers, CRP and ESR? □ **Yes** □ **No** ***Please provide documentation.***

Does patient continue to have a coronary artery aneurysm(s)? □ **Yes** □ **No** ***Please provide documentation.***

For diagnosis of recurrent pericarditis, answer the following:
Does patient have a CRP <0.5 mg/dL? □ **Yes** □ **No** ***Please provide documentation.***
Has patient had an episode of recurrent pericarditis? □ **Yes** □ **No** ***Please provide documentation.***

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP - 4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 877-228-7909

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