

**KINERET (Non-Preferred)**  
**PRIOR AUTHORIZATION FORM**

Kineret is a Non-Preferred agent on the Medical Assistance Preferred Drug List (PDL). To review the prior authorization guidelines, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter-Cytokine & CAM Antagonists (accessible at: <http://www.dhs.state.pa.us/publications/bulletinsearch/index.htm>).

**PRIOR AUTHORIZATION REQUEST INFORMATION**

New       Renewal       Additional Information (PA#: \_\_\_\_\_)  
# pages in this request: \_\_\_\_\_ Office Contact Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**RECIPIENT INFORMATION**

Name: \_\_\_\_\_ Recipient ID#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Prescriber Name: \_\_\_\_\_ Specialty: \_\_\_\_\_  
NPI#: \_\_\_\_\_ OR MA Provider ID#: \_\_\_\_\_ State License#: \_\_\_\_\_  
Prescriber Address: \_\_\_\_\_ Suite #: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_  
Long-term care facility (if applicable) contact name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**MEDICAL INFORMATION**

**Kineret Strength:** \_\_\_\_\_ **Dose:** \_\_\_\_\_ **Quantity:** \_\_\_\_\_ **Refills:** \_\_\_\_\_  
**Weight (if weight-based dosing):** \_\_\_\_\_ **kg** **Diagnosis:** \_\_\_\_\_ **Diagnosis Code:** \_\_\_\_\_ (Required)  
**Specialty Pharmacy Drug Program:** Which Specialty pharmacy will be used?  Diplomat Specialty  Walgreens Specialty  
**Specialist Type:**  Rheumatologist  Other: \_\_\_\_\_

**Check all that apply to the Recipient and submit documentation**

- Screened for Tuberculosis  
 Screened for Hepatitis B (antibody and/or surface antigen)  
 Up-to-date with immunizations (If less than 21 years old, in accordance with EPSDT guidelines)

**INITIAL REQUEST:**

**Rheumatoid Arthritis: Check all that apply and submit documentation**

- Recipient tried & failed (or has a contraindication or intolerance to) at least 3 months of treatment with methotrexate or other DMARD:  methotrexate  Other DMARD: \_\_\_\_\_  
 Recipient tried & failed (or has a contraindication or intolerance to) the Preferred agents:  Enbrel  Humira  
 Recipient recently had serum creatinine measured

**Other Indications:** Submit clinical documentation of diagnosis, supporting medical literature, and therapies that have been tried

**ALL RENEWAL REQUESTS:**

**Check all that apply and submit documentation**

- While on Kineret, the Recipient experienced an improvement in his/her condition and/or level of functioning  
 Recipient recently had serum creatinine measured

**PLEASE FAX COMPLETED FORM & SUPPORTING CLINICAL INFORMATION TO DHS – PHARMACY DIVISION**

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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