Kineret® (anakinra)

Medication Request Form (MRF) for Healthy Indiana Plan (HIP) and Hoosier Healthwise (HHW)
FAX TO: (858) 790-7100
c/o MedImpact Healthcare Systems, Inc.

Attn: Prior Authorization Department
10181 Scripps Gateway Court, San Diego, CA 92131 - Phone: 1-800-788-2949

Instructions:
This form is to be used by participating providers to obtain coverage for the drug listed above which requires *prior authorization*. Please complete this form and fax it to *Med**Impact*** Healthcare Systems, Inc. at (858) 790-7100. If you have any questions regarding this process, please contact Med***Impact***'s Customer Service at (800) 788-2949.

Member/Provider Information:

MDwise Member's Name:	Provider's Name:
MDwise Member's ID #:	**Provider's Specialty:**
MDwise Member's DOB (mm-dd-yy):	**Provider's DEA #:** | **Provider's NPI #:**
Pharmacy used by MDwise Member:	**Provider's Telephone Number/Contact Name (xxx-xxx-xxxx):**
Pharmacy Telephone Number (xxx-xxx-xxxx):	**Provider's Fax Number (xxx-xxx-xxxx):**

Clinical Information:

Requested Drug: ☐ Kineret®	Dose and Quantity Requested:
Date Requested:	**Length of Treatment** (please be specific):

Documentation of Medical Necessity (please complete **one** of the following two sections and if desired section #3):

1. Does the patient have a diagnosis of Neonatal-Onset Multisystem Inflammatory Disease (NOMID) Cryopyrin-Associated Periodic Syndromes (CAPS)? ☐ Yes ☐ No

   AND

   Is this for initial therapy (i.e. is the patient naïve to this medication)? ☐ Yes ☐ No

   If no, has the patient experienced or maintained symptomatic improvement while on therapy? ☐ Yes ☐ No

2. Does the patient have a diagnosis of moderate to severe rheumatoid arthritis? ☐ Yes ☐ No

AND

Is this for initial therapy (i.e., is the patient naïve to this medication)? ☐ Yes ☐ No

If no, has the patient experienced or maintained ≥20% improvement in tender or swollen joint count while on therapy? ☐ Yes ☐ No

AND

Has this treatment been prescribed by or in consultation with a rheumatologist? ☐ Yes ☐ No

AND

Has the patient tried or does the patient have a contraindication (CI) to at least **ONE** of the following DMARDs?

methotrexate	☐ Yes	☐ No	**If yes**, describe the response/reaction or CI to each medication below:
leflunomide	☐ Yes	☐ No	
hydroxychloroquine	☐ Yes	☐ No	
sulfasalazine	☐ Yes	☐ No	

AND

Has the patient tried at least **TWO** of the following preferred formulary agents?

Actemra® SC	☐ Yes	☐ No
Cimzia	☐ Yes	☐ No
Enbrel	☐ Yes	☐ No
Orencia® SC	☐ Yes	☐ No
Simponi	☐ Yes	☐ No
Xeljanz®	☐ Yes	☐ No

If yes, please describe the response/reaction to each medication below:

3. Please attach additional information which may indicate ***why this specific medication*** is being requested for this patient.