US Family Health Plan
Prior Authorization Request Form for
anakinra **(Kineret)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

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:

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]