USFHP 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 855-273-5735

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

https://www.usfamilyhealth.org/for-providers/pharmacy-information/

Prior authorization does not expire. Clinical documentation may be required.

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. How old is the patient?	☐ Pediatric patient (less than 18 years old) - Proceed to question **2** ☐ Adult patient (18 years of age or older) - Proceed to question **3**	
2. What is the indication or diagnosis in this pediatric patient?	☐ Neonatal Onset Multisystem Inflammatory Disease (NOMID), a subset of Cryopyrin-Associated Periodic Syndrome (CAPS) - Proceed to question **10** ☐ Systemic Juvenile Idiopathic Arthritis (sJIA) - Proceed to question **10** ☐ Deficiency of Interleukin-1 Receptor Antagonist (DIRA) - Proceed to question **10** ☐ Other - **STOP Coverage not approved**	
3. What is the indication or diagnosis in this adult patient?	☐ Moderate to severe active rheumatoid arthritis - Proceed to question **4** ☐ Adult-Onset Still's Disease (AOSD) - Proceed to question **9** ☐ Other – **STOP Coverage not approved**	
4. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	☐ Yes Proceed to question **5**	☐ No Proceed to question **7**
5. Has the patient had an inadequate response to Humira?	☐ Yes Proceed to question **8**	☐ No Proceed to question **6**
6. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**

7. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Has the patient had an inadequate response to 1 or more non-biologic systemic therapy (for example: methotrexate, aminosalicylates [for example, sulfasalazine, mesalamine], corticosteroids, immunosuppressants [for example, azathioprine])?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
9. Does the patient have Adult-Onset Still's Disease (AOSD) with active systemic features of moderate to high disease activity?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Will the patient be receiving other targeted immunomodulatory biologics with Kineret, including but not limited to the following: adalimumab (Humira), etanercept (Enbrel), certolizumab (Cimzia), golimumab (Simponi), infliximab (Remicade), apremilast (Otezla), ustekinumab (Stelara), abatacept (Orencia), tocilizumab (Actemra), tofacitinib (Xeljanz/Xeljanz XR), rituximab (Rituxan), secukinumab (Cosentyx), ixekizumab (Taltz), brodalumab (Siliq), sarilumab (Kevzara), guselkumab (Tremfya), baricitinib (Olumiant), tildrakizumab (Ilumya), risankizumab-rzaa (Skyrizi), or upadacitinib (Rinvoq ER)?	☐ 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