

# Kineret (anakinra)

## Prior Authorization Request (Physician to Complete)



Visit [www.wellmark.com](http://www.wellmark.com) for the Wellmark Drug List for current medication tier levels and updated PA Forms

### Facsimile Transmittal Sheet

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

To: Wellmark Pharmacy Services

From (Prescriber's Name): \_\_\_\_\_

Fax Number: (866) 884-4345

Prescriber's DEA Number: \_\_\_\_\_

Phone Number: (800) 600-8065

Prescriber's Phone Number: \_\_\_\_\_

Prescriber's Specialty: \_\_\_\_\_

Prescriber's Fax Number: \_\_\_\_\_

Prescriber's Office Address: \_\_\_\_\_  
Street Suite # City State Zip

Patient Name: \_\_\_\_\_

Patient ID: \_\_\_\_\_ Patient DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please answer the following questions and fax this form back to (866) 884-4345. All fields are REQUIRED.

1. Please provide the diagnosis this therapy has been prescribed for: \_\_\_\_\_

ICD-9 Code: \_\_\_\_\_

2. Does the patient have any of the poor prognostic factors for rheumatoid arthritis listed below?

Please check all that apply:

- |   |   |
|---|---|
| <input type="checkbox"/> Functional limitation            | <input type="checkbox"/> Extraarticular disease         |
| <input type="checkbox"/> Rheumatoid Factor positive (RF+) | <input type="checkbox"/> RA Lung disease                |
| <input type="checkbox"/> Felty's syndrome                 | <input type="checkbox"/> RA Vasculitis                  |
| <input type="checkbox"/> Secondary Sjogren's syndrome     | <input type="checkbox"/> Presence of rheumatoid nodules |
| <input type="checkbox"/> Positive anti-CCP                | <input type="checkbox"/> Bony erosions by radiography   |

3. Has the patient shown inadequate response to at least ONE of the following systemic agents?  Yes  No

Please check all that apply:

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> azathioprine       | <input type="checkbox"/> methotrexate    | <input type="checkbox"/> leflunomide   | <input type="checkbox"/> oral or injectable gold |
| <input type="checkbox"/> hydroxychloroquine | <input type="checkbox"/> D-penicillamine | <input type="checkbox"/> sulfasalazine |  |

contraindication: \_\_\_\_\_

4. Prescriber's specialty: \_\_\_\_\_

5. Is the patient concomitantly receiving any of the following medications?  Yes  No Please check all that apply:

- |  |  |
|--|--|
| <input type="checkbox"/> Cimzia (certolizumab pegol) | <input type="checkbox"/> Humira (adalimumab)   |
| <input type="checkbox"/> Enbrel (etanercept)         | <input type="checkbox"/> Remicade (infliximab) |

6. Dose per injection: \_\_\_\_\_ mg Frequency of injection: \_\_\_\_\_ per \_\_\_\_\_

**Attach lab results and other documentation as necessary**

Printed Name \_\_\_\_\_

Signature \_\_\_\_\_

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