Kineret® (anakinra)
Prior Authorization Form

ROCKY MOUNTAIN HEALTH PLANS®
We understand Colorado. We understand you.

Complete Patient and Physician information (PLEASE PRINT)

STEP 1

Member Name:	Physician Name:
Address:	Address:
Member ID:	Phone #:
Member DOB:	Fax #:

If Applicable: Pharmacy Name: _____
Pharmacy Phone: _____

Complete the Clinical Assessment:

STEP 2

Diagnosis	☐ Moderate to severe active Rheumatoid Arthritis		☐ Other (please state):
Clinical Consideration	Patients with rheumatoid arthritis must have tried and failed therapy with a Disease Modifying Antirheumatic Drug (DMARD) Patient tried and failed: ☐ Methotrexate ☐ hydroxychloroquine (Plaquenil) ☐ gold salts (Ridaura, Myochrysine, Solganol) ☐ d-penicillamine (Cuprimine) ☐ Arava ☐ sulfasalazine (Azulfidine) ☐ azathioprine (Imuran) ☐ cyclophosphamide (Cytoxan) ☐ cyclosporine (Sandimmune, Neoral)		
Physician Specialty	☐ Rheumatology	☐ Physician experienced with Kineret therapy	☐ Other (please state):
Supporting Documentation	Diagnosis: ICD-9 Code #/ Description (required):		
	Please attach a copy of the prescription or provide ALL of the information below: Kineret® (anakinra) Strength _____ Sig _____ Qty _____ Refills _____		
	Please attach all relevant medical records and test results. **Incomplete forms will not be processed.**		

STEP 3

I certify that the above is correct and accurate to the best of my knowledge (please sign and date).

_____ _____
Prescriber Signature Date

STEP 4

Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk:
970-248-5034

Pharmacy Technician initials _____ Date Initiated _____

Confidentiality Notice:

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