

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM  
**KINERET**(anakinra)

Patient name: \_\_\_\_\_ Medicaid ID #: \_\_\_\_\_  
Prescriber Name: \_\_\_\_\_ Prescriber NPI#: \_\_\_\_\_ Contact person: \_\_\_\_\_  
Prescriber Phone#: \_\_\_\_\_ Extension/Option: \_\_\_\_\_ Fax#: \_\_\_\_\_  
Pharmacy: \_\_\_\_\_ Pharmacy Phone#: \_\_\_\_\_ Pharmacy Fax #: \_\_\_\_\_  
Requested Medication: \_\_\_\_\_ Strength: \_\_\_\_\_ Frequency/Day: \_\_\_\_\_

**All information to be legible, complete and correct or form will be returned**

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**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF  
MEDICAL NECESSITY TO 855-828-4992** note the new fax number

**CRITERIA:**

- Age requirement: 18 years and older
- Diagnosis of moderate to severe Rheumatoid Arthritis
- History of treatment failure, incomplete response or intolerance to Methotrexate, or one other DMARD or second line drug (azathioprine, sulphadiazine, leflunomide, penicillamine, hydroxychloroquine, etc.)
- The number of swollen joints, must be 6 or more (**WRITE SPECIFIC NUMBER IN NOTES OR LETTER**)
- The number of tender joints must be 9 or more. (**WRITE SPECIFIC NUMBER IN NOTES OR LETTER**)
- Absence of active bacterial or viral infection, malignancy, or immunosuppressive condition.
- Negative TB skin test or history of treatment for latent TB infection.
- Rheumatology consultation within the last 60 days.
- May not be given with other biologic agents such as Interferon, experimental medications or combinations.

**AUTHORIZATION:**

1 year

**RE-AUTHORIZATION:**

An updated letter of medical necessity or progress notes showing improvement or maintenance with medication.

9/21/10

<http://health.utah.gov/medicaid/pharmacy>