



Prior Authorization Form

**Arkansas Blue Cross and Blue Shield (Medicare)  
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)  
Kineret (Medicare Determination)**

This fax machine is located in a secure location as required by HIPAA regulations.  
Complete/review information, sign and date. Fax signed forms to CVS|Caremark at 1-888-836-0730.  
Please contact CVS|Caremark at 1-800-294-5979 with questions regarding the prior authorization process.  
When conditions are met, we will authorize the coverage of Kineret (Medicare Determination).

**Drug Name (select from list of drugs shown)**  
Kineret (anakinra)

**Patient Information**

Patient  
Name: \_\_\_\_\_  
Patient ID: \_\_\_\_\_  
Patient  
Group No.: \_\_\_\_\_  
Patient  
DOB: \_\_\_\_\_

**Prescribing Physician**

Physician  
Name: \_\_\_\_\_  
Physician  
Phone: \_\_\_\_\_  
Physician  
Fax: \_\_\_\_\_  
Physician  
Address: \_\_\_\_\_  
City, State,  
Zip: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code: \_\_\_\_\_

Please circle the appropriate answer for each applicable question.

- |  |   |   |
|--|---|---|
| 1. Is the physician purchasing and providing the drug "incident to" physician services?  | Y | N |
| 2. Does the patient have the diagnosis of moderate to severe active rheumatoid arthritis?  | Y | N |
| 3. Has the patient failed or had an inadequate response to a trial of at least one Disease Modifying Antirheumatic Drug (DMARD)?<br>[If the answer to this question is yes, may skip to question 5.]   | Y | N |
| 4. Is patient intolerant to DMARDs?  | Y | N |
| 5. Is the patient receiving a biologic response modifier, such as tumor necrosis factor (TNF) blocking agent [e.g., Cimzia, Enbrel, Humira, Remicade], selective co-stimulation modulator (e.g., Orencia), or monoclonal antibody to B cells (e.g., Rituxan)?<br>[If the answer to this question is no, may skip to question 7.] | Y | N |
| 6. Will the Biologic Response Modifier be discontinued?<br>[If the answer to this question is no, no further questions required.]  | Y | N |
| 7. Does the patient have an active infection?  | Y | N |



**Arkansas  
BlueCross BlueShield**  
An Independent Licensee of the Blue Cross and Blue Shield Association

**Comments:**

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I affirm that the information given on this form is true and accurate as of this date.

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**Prescriber (Or Authorized) Signature and Date**