

- Preferred drug accepted. New verbal order authorized.
- Preferred drug rejected by physician.

**Health New England**  
**Medication Request Form (MRF)/Prescription Request**  
**Kineret® (anakinra)**

**Prior Authorization**

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

**Instructions:**

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Kineret®. Please complete this form and fax to ICORE Healthcare at (866) 364-2673. If you have any questions regarding this process, please contact ICORE Healthcare at (800) 775-5138.

**J-Codes:** Kineret® J3590, unit = 1 (if administered in physicians office only)

**Medication Request Information (please complete each section of this form prior to transmittal):**

Patient Information (all required)	Physician Information (all required)
<b>Patient Name:</b>	<b>Physician Name:</b>
	<b>Specialty:</b>
<b>Patient Cell Phone #:</b> (     )     -	<b>NPI#:</b>
<b>Patient HNE ID#:</b>	<b>HNE Provider #:</b>
<b>Patient Date of Birth:</b>	<b>DEA #:</b>
<b>Allergies:</b>	<b>Telephone #:</b> (     )     -
<b>Diagnosis:</b>	<b>Fax #:</b> (     )     -

**Drug Information**

<b>Preferred Drug:</b> <input type="checkbox"/> Humira <input type="checkbox"/> Enbrel		
<b>Requested Drug/Strength/Form:</b>		
<b>Dose, Directions, and length of treatment (please be specific):</b>	<b>Quantity (per month):</b>	<b>Refills:</b>

<b>Physician Signature:</b>	<b>Date:</b>
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**Indication:**

Moderate to Severe Rheumatoid Arthritis.

Other (please describe): \_\_\_\_\_

**Documentation of Medical Necessity (check all that apply):**

Patient has tried and failed Humira\Enbrel  Yes  No

Patient has been seen by a Rheumatologist within the previous 12 months. (required)

Request is for continuation of therapy

Patient is intolerant to or failed therapy of at least one (1) DMARD or immunomodulator (including methotrexate, sulfasalazine, hydroxychloroquine, aurothioglucose, auranofin, gold sodium thiomalate, azathioprine, d-penicillamine, cyclosporine, infliximab, etanercept, or leflunomide).

Active infections have been excluded (required). (including but not limited to chronic or localized infections, histoplasmosis, cytomegalovirus, tuberculosis, HIV)

Patient will not receive Arava® (leflunomide), Enbrel® (etanercept), Humira® (adalimumab), Remicade (infliximab) or Orencia (abatacept) along with Kineret.

Other pertinent history: \_\_\_\_\_