SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Kineret™ (anakinra) **(Non-Preferred)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

Recommended dose and quantity limit: One syringe per day (maximum quantity 30/30 days)

CLINCIAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ **Diagnosis: Moderate to severe Active Rheumatoid Arthritis**
  - ❑ Prescriber is a Rheumatologist

    AND
  - ❑ Patient is at least 18 years old and diagnosed with **moderate to severely active rheumatoid arthritis**

    AND

(Continued on next page)

- ❑ Trial and failure of methotrexate

OR

- ❑ Medication requested will be used in conjunction with methotrexate

OR

- ❑ Patient has a contraindication to methotrexate (e.g., alcohol abuse, cirrhosis, chronic liver disease, or other contraindication)

AND

- ❑ Trial and failure of at least **ONE (1) other DMARD** **(check each tried):**

❑ azathioprine	❑ leflunomide	❑ auranofin	❑ sulfasalazine
❑ hydroxychloroquine	❑ minocycline	❑ Other: __	

AND

- ❑ Trial and failure of **TWO (2)** of the **PREFERRED** biologics below:

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ **Diagnosis: Cryopyrin-Associated Periodic Syndromes (CAPS)**
Approvable with confirmation of this diagnosis.

- ❑ Cryopyrin -Associated Periodic Syndromes (CAPS), including:
  - ❑ Treatment of Neonatal-Onset Multisystem Inflammatory Disease

❑ **Diagnosis: Deficiency of Interleukin-1 Receptor Antagonist (DIRA)**
Approvable with confirmation of this diagnosis.

- ❑ Deficiency of Interleukin-1 Receptor Antagonist (DIRA)

Medication being provided by (check applicable box(es) below):

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy – PropriumRx**

Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.