

**Kineret  
Prior Authorization Request**

**Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155**

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506**. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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**Patient's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Patient's ID:** \_\_\_\_\_ **Patient's Date of Birth:** \_\_\_\_\_  
**Physician's Name:** \_\_\_\_\_  
**Specialty:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Physician Office Telephone:** \_\_\_\_\_ **Physician Office Fax:** \_\_\_\_\_  
**Request Initiated For:** \_\_\_\_\_

1. Has the patient been diagnosed with any of the following?
  - Rheumatoid arthritis (RA), moderately to severely active
  - Adult-onset Still's disease
  - Systemic juvenile idiopathic arthritis (sJIA), active
  - Cryopyrin-Associated Periodic Syndrome (CAPS), including Neonatal-Onset Multisystem Inflammatory Disease (NOMID)
  - Recurrent pericarditis
  - Multicentric Castleman's disease
  - Hyperimmunoglobulin D Syndrome [Mevalonate Kinase Deficiency (MKD)]
  - Polyarticular juvenile idiopathic arthritis
  - Other \_\_\_\_\_

2. What is the ICD-10 code? \_\_\_\_\_  
*No further questions if diagnosis is CAPS (NOMID), multicentric Castleman's disease or Hyperimmunoglobulin D Syndrome.*

Section A: Preferred Product

3. These are the formulary preferred products for which coverage is provided for treatment of the following conditions:  
 Rheumatoid arthritis: **Enbrel, Humira, Kevzara, Orencia (subcutaneous)/Orencia ClickJect**  
 Can the patient's treatment be switched to a preferred product?  
 Yes - Please specify: \_\_\_\_\_ *If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: [www.covermymeds.com/epa/caremark/](http://www.covermymeds.com/epa/caremark/) or call 1-866-452-5017.*  
 No  
 Not applicable - Requested for condition not listed above, skip to diagnosis section.

4. Is this request for continuation of therapy with the requested product?  Yes  No *If No, skip to #6*

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5. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer Yes.  Yes  No *If No, skip to diagnosis section.*

6. Has the patient had a documented inadequate response or intolerable adverse event with ALL of the preferred products (Cosentyx, Enbrel, and Humira)? Please indicate ALL that apply.

**ACTION REQUIRED: If Yes, attach supporting chart note(s).**

Enbrel:  Inadequate response  Intolerable adverse event

Humira:  Inadequate response  Intolerable adverse event

Kevzara:  Inadequate response  Intolerable adverse event

Orencia (SC/ClickJect):  Inadequate response  Intolerable adverse event

No - none of the above, *complete this form in its entirety and Maryland State Step Therapy section.*

7. Does the patient have one of the following documented clinical reasons to avoid Enbrel and Humira?

**ACTION REQUIRED: If Yes, attach supporting chart note(s).**

Yes - History of demyelinating disorder

Yes - History of congestive heart failure

Yes - History of hepatitis B virus infection

Yes - Autoantibody formation/lupus-like syndrome

Yes - Risk of lymphoma

No - none of the above, *complete this form in its entirety and Maryland State Step Therapy section.*

**Complete the following section based on the patient's diagnosis, if applicable.**

Section B: Adult-Onset Still's Disease

8. How long has the patient been receiving the requested medication? \_\_\_\_\_ months  Not started, *skip to #10*

9. If patient has received at least 3 months, has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms?

Yes  No *No further questions*

10. Has the patient experienced an inadequate response after at least 3 months of treatment OR intolerance to methotrexate?  Yes  No

11. Does the patient have a febrile disease?  Yes  No

12. Does the patient have a contraindication to methotrexate?  Yes  No

Section C: Recurrent Pericarditis

13. Has the patient failed a first-line therapy agent for the treatment of recurrent pericarditis (i.e., colchicine)?  Yes  No

Section D: Rheumatoid Arthritis

14. How long has the patient been receiving the requested medication? \_\_\_\_\_ months  Not started, *skip to #16*

15. If patient has received at least 3 months, has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms?

Yes  No *No further questions*

16. Has the patient experienced an inadequate response after at least 3 months of treatment OR intolerance to a biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz)?  Yes  No

Section E: Systemic Juvenile Idiopathic Arthritis

17. How long has the patient been receiving the requested medication? \_\_\_\_\_ months  Not started, *skip to #19*

18. If patient has received at least 3 months, has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms?

Yes  No *No further questions*

19. Has the patient received Actemra or Ilaris in a paid claim through a pharmacy or medical benefit in the previous 120 days?  Yes  No
20. Has the patient experienced an inadequate response to treatment with corticosteroids (e.g., prednisone, methylprednisolone), methotrexate, or leflunomide?  Yes  No

Maryland State Step Therapy

1. Is the requested drug being used to treat stage four advanced metastatic cancer?  Yes  No *If No, skip to #3*
2. Is the requested drug's use consistent with the FDA-approved indication or the National Comprehensive Cancer Network Drugs & Biologics Compendium indication for the treatment of stage four advanced metastatic cancer and is supported by peer-reviewed medical literature?  Yes  No
3. Is the requested drug being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?  Yes  No
4. Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?  Yes  No
5. Do patient chart notes document the requested drug was ordered with a paid claim at the pharmacy, the pharmacy filled the prescription and delivered to the patient or other documentation that the requested drug was prescribed for the patient in the last 180 days?  Yes  No
6. Has the prescriber provided proof documented in the patient chart notes that in their opinion the requested drug is effective for the patient's condition?  Yes  No

*I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.*

X \_\_\_\_\_

**Prescriber or Authorized Signature**

**Date (mm/dd/yy)**