aetna®

Kineret® (anakinra) Injectable Medication Precertification Request

(Please complete all fields and return both pages for precertification review)

Aetna Precertification Notification
Phone: 1-855-240-0535
FAX: 1-877-269-9916

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start Date ____/____/____
☐ Continuation of therapy, date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:
Patient Current Weight: _____ lbs or _____ kgs	Patient Height: _____ inches or _____ cms	Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Rheumatologist** ☐ **Other**:

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for anakinra (Kineret): Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD Code and specify any other any other where applicable (*).

Primary ICD Code: ☐ _____ Additional ICD code(s): ☐ _____

G. CLINICAL INFORMATION - Required clinical information must be completed for ALL precertification requests.

For initiation requests (clinical documentation required):

☐ Yes ☐ No Will anakinra (Kineret) be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, infliximab)?

☐ Yes ☐ No Has the patient been tested for TB with a PPD test, interferon-release assay (IGRA) or chest x-ray within 6 months of initiating a biologic therapy?
→ (check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray
Please enter the date and results of the TB test: Date: ____/____/____ Results: ☐ Positive ☐ Negative ☐ Unknown
If positive, Does the patient have latent or active TB? ☐ Latent ☐ Active
If latent TB, ☐ Yes ☐ No Will TB treatment be started before initiation of therapy with anakinra (Kineret)

Castleman's Disease

☐ Yes ☐ No Does the patient have a diagnosis of multicentric Castleman's disease?
☐ Yes ☐ No Is anakinra (Kineret) being used as subsequent therapy for multicentric Castleman's disease?
☐ Yes ☐ No Is anakinra (Kineret) being used as a monotherapy?
Please select which of the following applies to the patient's disease? ☐ Relapsed/refractory disease ☐ Progressive disease
☐ Yes ☐ No Has the disease progressed following treatment of relapsed/refractory or progressive disease?
→ Please provide medication name and date range: Name: _____ Dates: ____/____/____ - ____/____/____

Cryopyrin-Associated Periodic Syndromes (CAPS)

Please select which of the following applies to the patient: ☐ Familial cold autoinflammatory syndrome (FCAS) ☐ Muckle-Wells syndrome (MWS)
☐ Neonatal-onset multisystem inflammatory disease (NOMID), also known as chronic infantile neurological cutaneous articular (CINCA) syndrome
☐ Other: _____

Pericarditis

☐ Yes ☐ No Does the patient have a documented diagnosis of corticosteroid-dependent pericarditis?
☐ Yes ☐ No Is there clinical evidence that the disease is recurrent?
☐ Yes ☐ No Has the patient been unresponsive to treatment with colchicine?
→ Please provide the date range of the trial: Dates: ____/____/____ - ____/____/____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

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Rheumatoid Arthritis

Please indicate the severity of the patient's rheumatoid arthritis: ☐ Mild ☐ Moderate ☐ Severe

☐ Yes ☐ No Is there evidence that the disease is active?

How many of the following medications have been ineffective, not tolerated, or contraindicated: Enbrel, Inflectra, Remicade, Renflexis, Simponi, Simponi Aria, Xeljanz/Xeljanz XR?

☐ 0 ☐ 1 ☐ 2 ☐ 3 or more

Please indicate the ***first*** medication that has been ineffective, not tolerated, or contraindicated:

☐ Enbrel ☐ Inflectra ☐ Remicade ☐ Renflexis ☐ Simponi ☐ Simponi Aria ☐ Xeljanz/Xeljanz XR

Was treatment ineffective, not tolerated, or contraindicated? ☐ ineffective ☐ not tolerated ☐ contraindicated

Please provide the date range of the trial: Date range: ____/____/____ - ____/____/____

Please indicate the ***second*** medication that has been ineffective, not tolerated, or contraindicated:

☐ Enbrel ☐ Inflectra ☐ Remicade ☐ Renflexis ☐ Simponi ☐ Simponi Aria ☐ Xeljanz/Xeljanz XR

Was treatment ineffective, not tolerated, or contraindicated? ☐ ineffective ☐ not tolerated ☐ contraindicated

Please provide the date range of the trial: Date range: ____/____/____ - ____/____/____

Please indicate the ***third*** medication that has been ineffective, not tolerated, or contraindicated:

☐ Enbrel ☐ Inflectra ☐ Remicade ☐ Renflexis ☐ Simponi ☐ Simponi Aria ☐ Xeljanz/Xeljanz XR

Was treatment ineffective, not tolerated, or contraindicated? ☐ ineffective ☐ not tolerated ☐ contraindicated

Please provide the date range of the trial: Date range: ____/____/____ - ____/____/____

Schnitzler Syndrome

☐ Yes ☐ No Does the patient have a documented diagnosis of Schnitzler syndrome characterized by chronic, nonpruritic urticaria in association with recurrent fever, bone pain, arthralgia, or arthritis?

☐ Yes ☐ No Does the patient have documented monoclonal immunoglobulin M (IgM) gammopathy (present in all cases)?

Still's Disease

☐ Yes ☐ No Does the patient have a documented diagnosis of adult-onset Still's disease?

Was treatment with glucocorticoids (e.g. dexamethasone, hydrocortisone, prednisone, etc.) ineffective, not tolerated, or contraindicated?

☐ ineffective ☐ not tolerated ☐ contraindicated

Please provide glucocorticoids name and date range: Name: _____ Dates: ____/____/____ - ____/____/____

Was the treatment with methotrexate ineffective, not tolerated, or contraindicated? ☐ ineffective ☐ not tolerated ☐ contraindicated

Please provide date range of methotrexate trial: Dates: ____/____/____ - ____/____/____

Was treatment with a TNF-alpha inhibitor ineffective, not tolerated, or contraindicated? ☐ ineffective ☐ not tolerated ☐ contraindicated

Please provide TNF-alpha inhibitor name and date range: Name: _____ Dates: ____/____/____ - ____/____/____

Systemic Juvenile Idiopathic Arthritis (SJIA)

☐ Yes ☐ No Does the patient have active systemic juvenile idiopathic arthritis?

☐ Yes ☐ No Does the patient have initial symptoms that include high fevers and painful polyarthritis?

☐ Yes ☐ No Was the treatment with a non-steroidal anti-inflammatory drug (NSAID) monotherapy ineffective?

→ Please provide the name and date range of the NSAID tried:

Name: _____ Dates: ____/____/____ - ____/____/____

For Continuation of Therapy (clinical documentation required for all requests):

Please indicate the length of time on anakinra (Kineret): _____

☐ Yes ☐ No Is this continuation request a result of the patient receiving samples of anakinra (Kineret)? (Sampling of Kineret does not guarantee coverage under the provisions of the pharmacy benefit)

☐ Yes ☐ No Will anakinra (Kineret) be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, infliximab)?

☐ Yes ☐ No Is there clinical documentation supporting disease stability?

☐ Yes ☐ No Is there clinical documentation supporting disease improvement?

☐ Yes ☐ No Does the patient have any risk factors for TB?

→ ☐ Yes ☐ No Has the patient had a TB test within the past year?

(check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray

Please enter the date and results of the TB test: Date: ____/____/____ Results: ☐ Positive ☐ Negative ☐ Unknown

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.