BlueCross BlueShield Federal Employee Program

KINERET
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Kineret (anakinra)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Has the patient been receiving Kineret therapy for at least **6 months** continuously excluding samples? ***Please select answer below:***
   ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 3**
   ❑ **NO** – this is **INITIATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Has the patient been tested for latent tuberculosis (TB)? ❑Yes* ❑No
   If YES, was the result of the test positive or negative for TB infection? ❑Positive* ❑Negative
   If POSITIVE, has the patient completed treatment or is the patient currently receiving treatment for latent TB? ❑Yes ❑No
4. Does the patient have any active bacterial, invasive fungal, viral, or other opportunistic infections? ❑Yes ❑No
5. Is the patient at risk for hepatitis B virus (HBV) infection? ❑Yes* ❑No
   If YES, has hepatitis B virus (HBV) infection been ruled out or has the patient already started treatment for the HBV infection? ❑Yes ❑No
6. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
7. Will Kineret be used in combination with any other biologic *DMARD or targeted synthetic DMARD? ❑Yes* ❑No
   If YES, please specify the medication: _____
   DMARDs: Actemra or an Actemra biosimilar, Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra.
8. What is the patient's diagnosis?
   ❑ Adult-onset Still's disease ❑ Gout ❑ Systemic juvenile idiopathic arthritis (sJIA)
   ❑ CAR T Cell-Related Toxicities ❑ Pseudogout (calcium pyrophosphate deposition)
   ❑ Cryopyrin-Associated Periodic Syndrome (CAPS)
      a. Does the patient have neonatal-onset multisystem inflammatory disease (NOMID)? ❑Yes ❑No
      b. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 8 milligrams per kilogram (mg/kg) per day? ❑Yes ❑No
   ❑ Deficiency of Interleukin-1 Receptor Antagonist (DIRA)
      a. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 8 milligrams per kilogram (mg/kg) per day? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ **DOB:** _____ **Patient ID: R** _____

❑ Rheumatoid Arthritis (RA)

a. **Standard or Basic Option Patient** (**for claims adjudicated through the pharmacy benefit**)**:** Humira or a Humira biosimilar, Actemra SC or an Actemra SC biosimilar, Enbrel, Rinvoq, and Xeljanz/Xeljanz XR are preferred products. Patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year. ***Please answer the following question:***

i. Has the patient tried and failed Humira or a Humira biosimilar, Enbrel, Rinvoq, or Xeljanz/Xeljanz XR? ***Answer below:***

❑**Yes:** Would you like to participate in this program and switch the patient to one of the preferred products? ❑Yes***** ❑No

****If YES***, select the medication: ❑Humira/preferred biosimilar ❑Actemra SC/preferred biosimilar ❑Enbrel ❑Rinvoq ❑Xeljanz/Xeljanz XR

❑**No**: Would you like to participate in this program and switch the patient to one of the preferred products? ❑Yes***** ❑No

****If YES***, select the medication: ❑Humira/preferred biosimilar ❑Enbrel ❑Rinvoq ❑Xeljanz/Xeljanz XR

b. Does the patient have moderate to severely active rheumatoid arthritis (RA)? ❑Yes ❑No

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 3-month trial of at least one conventional disease modifying anti-rheumatic drug (DMARD)? ❑Yes ❑No

d. Does the prescriber agree to administer Kineret within the FDA labeled maintenance dose of 100mg per day? ❑Yes ❑No

e. **Standard or Basic Option Patient, for claims adjudicated through the pharmacy benefit:** Does the patient have an intolerance or contraindication** or have they had an inadequate treatment response to TWO of the following preferred medications: Humira or a Humira biosimilar, Actemra SC or an Actemra SC biosimilar, Enbrel, Rinvoq, or Xeljanz/Xeljanz XR? ❑Yes ❑No*

****If NO,*** is there a clinical reason for not trying TWO of the preferred medications? ❑Yes ❑No

*****Contraindications include (not all inclusive): allergy, autoantibody formation/lupus-like syndrome, or a history of congestive heart failure, hepatitis B virus infection, malignancy, or demyelinating disorder such as multiple sclerosis, Guillain-Barre syndrome, or optic neuritis.***

❑ Other diagnosis ***(please specify):*** _____

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Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

CONTINUATION OF THERAPY (PA RENEWAL)

Kineret (anakinra)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Has the patient been receiving Kineret therapy for at least **6 months** continuously excluding samples? ***Please select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 1**
   ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below:

2. Is this request for brand or generic? ❑Brand ❑Generic

3. Has the patient's condition improved or stabilized with therapy? ❑Yes ❑No

4. Does the patient have any active infections including tuberculosis (TB) and hepatitis B virus (HBV)? ❑Yes ❑No

5. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No

6. Is Kineret going to be used in combination with any other biologic *DMARD or targeted synthetic DMARD? ❑Yes* ❑No
   If YES, please specify the medication: _____
   DMARDs: Actemra or an Actemra biosimilar, Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra.

7. What is the patient's diagnosis?
   ❑ Adult-onset Still's disease ❑ Gout ❑ Systemic juvenile idiopathic arthritis (sJIA)
   ❑ CAR T Cell-Related Toxicities ❑ Pseudogout (calcium pyrophosphate deposition)
   ❑ Cryopyrin-Associated Periodic Syndrome (CAPS)
   a. Does the patient have neonatal-onset multisystem inflammatory disease (NOMID)? ❑Yes ❑No
   b. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 8 milligrams per kilogram (mg/kg) per day? ❑Yes ❑No
   ❑ Deficiency of Interleukin-1 Receptor Antagonist (DIRA)
   a. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 8 milligrams per kilogram (mg/kg) per day? ❑Yes ❑No

PLEASE PROCEED TO PAGE 4 FOR ADDITIONAL DIAGNOSES

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PAGE 4 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑ Rheumatoid Arthritis (RA)

a. **Standard or Basic Option Patient** (**for claims adjudicated through the pharmacy benefit**)**:** Humira including preferred Humira biosimilars**,** Actemra SC including preferred Actemra SC biosimilars, Enbrel, Rinvoq, and Xeljanz/Xeljanz XR are preferred products. Patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year. ***Please answer the following question:***

i. Has the patient tried and failed Humira or a Humira biosimilar, Enbrel, Rinvoq, or Xeljanz/Xeljanz XR? ***Answer below:***

❑**Yes:** Would you like to participate in this program and switch the patient to one of the preferred products? ❑Yes***** ❑No

****If YES***, select the medication: ❑Humira/preferred biosimilar ❑Actemra SC/preferred biosimilar ❑Enbrel ❑Rinvoq ❑Xeljanz/Xeljanz XR

❑**No**: Would you like to participate in this program and switch the patient to one of the preferred products? ❑Yes***** ❑No

****If YES***, select the medication: ❑Humira/preferred biosimilar ❑Enbrel ❑Rinvoq ❑Xeljanz/Xeljanz XR

b. Does the prescriber agree to administer Kineret within the FDA labeled maintenance dose of 100mg per day? ❑Yes ❑No

c. **Standard or Basic Option Patient, for claims adjudicated through the pharmacy benefit:** Does the patient have an intolerance or contraindication** or have they had an inadequate treatment response to TWO of the following preferred medications: Humira or a Humira biosimilar, Actemra SC or an Actemra SC biosimilar, Enbrel, Rinvoq, or Xeljanz/Xeljanz XR? ❑Yes ❑No*

****If NO,*** is there a clinical reason for not trying TWO of the preferred medications? ❑Yes ❑No

*****Contraindications include (not all inclusive): allergy, autoantibody formation/lupus-like syndrome, or a history of congestive heart failure, hepatitis B virus infection, malignancy, or demyelinating disorder such as multiple sclerosis, Guillain-Barre syndrome, or optic neuritis.***

❑Other diagnosis ***(please specify):*** _____