CVS CAREMARK

Fax Referral To: 800-323-2445

Phone: 866-278-6634

Kineret® (anakinra)
Enrollment Form
For Blue Cross Blue Shield of Rhode Island Members

Date: _____ **Needs by Date (Please Specify):** _____

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other:** _____

PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
Last Four of SS #: _____ Primary Language: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

INSURANCE INFORMATION (*Please copy and attach the front and back of insurance and prescription drug card)*

Prescription Card: Name of Insurer: _____ ID#: _____ BIN: _____ PCN: _____ Group: _____
Primary Insurance: Subscriber: _____ ID#: _____ Name of **Blue Cross Blue Shield of RI** Phone: _____
Secondary Insurance: Subscriber: _____ ID#: _____ Name of _____ Phone: _____

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Diagnosis (ICD-9 code): ☐ 714.0 Rheumatoid Arthritis ☐ Other: _____ • Date of Diagnosis: _____

APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

REQUIRED FOR ALL

- Kineret will be used in combination with a TNF agent or abatacept (Orencia) ☐ Yes ☐ No
- Prior to initiating Kineret, patient has had an inadequate response to etanercept (Enbrel), adalimumab (Humira), or infliximab (Remicade)? ☐ Yes ☐ No
  - If no, does patient have a contraindication or intolerance to etanercept, adalimumab, or infliximab? ☐ Yes ☐ No

RHEUMATOID ARTHRITIS

- Patient has been diagnosed with moderate to severe active Rheumatoid Arthritis ☐ Yes ☐ No
- Patient is 18 years of age or older ☐ Yes ☐ No
- Patient has failed or had an inadequate response to one or more disease modifying antirheumatic agents (DMARDs): ☐ Yes ☐ No

☐ Azathioprine (Imuran) ☐ Hydroxychloroquine (Plaquenil)
☐ Methotrexate ☐ Auranofin (Ridaura)
☐ Penicillamine (Cuprimine, Depen) ☐ Sulfasalazine (Azulfidine)
☐ Cyclophosphamide ☐ Cyclosporine
☐ Minocycline ☐ Leflunomide
☐ Gold Sodium Thiomalate

- If no, does patient have a contraindication or intolerance to one or more DMARDs? ☐ Yes ☐ No

SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS/ADULT STILL'S DISEASE

- Patient currently has active systemic features (eg, fever) ☐ Yes ☐ No
  - Patient has had an inadequate response to systemic glucocorticoid therapy? ☐ Yes ☐ No
  - If no, does patient had a contraindication or intolerance to systemic glucocorticoid therapy? ☐ Yes ☐ No
- Patient currently has moderately to high active arthritis ☐ Yes ☐ No
  - Patient has had an inadequate response to methotrexate (MTX) ☐ Yes ☐ No
  - If no, does patient have a contraindication or intolerance to MTX ☐ Yes ☐ No

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Kineret® (anakinra)	100mg Prefilled Syringe	☐ Inject 100mg (one syringe) subcutaneously once a day ☐ Other: _____		

X _____
PRODUCT SUBSTITUTION PERMITTED (Date)

X _____
DISPENSE AS WRITTEN (Date)