VERMONT

KINERET® (anakinra) - Prior Authorization/Prescription/Patient Enrollment Form

Complete form in its entirety and fax to number listed below

1 PATIENT INFORMATION

Last Name	First Name	Middle Initial
Date of Birth	Sex M ☐ F ☐	Medicaid ID #

Allergies: ☐ NKA or _____

Street Address	City

State	County	Zip Code

Home Phone	Cell Phone

Parent/Guardian	Day Telephone	Night Telephone
Emergency Contact	Relationship	Telephone

2 PRESCRIBER INFORMATION

Prescriber's Name	NPI Number	DEA Number

Telephone Number	Fax Number	Hospital/Clinic Name

Street Address	City

State	County	Zip Code

Contact Person at Office	Prescriber Specialty

briovaRx

GHS Good Health Systems

Fax Completed Form to:

Fax Number: 800-218-3221

Phone Number: 866-843-3604

3 Department of Vermont Health Access KINERET® (anakinra) PRIOR AUTHORIZATION REQUEST

Patient Diagnosis:

☐ Rheumatoid Arthritis

If requesting prescriber is not a Rheumatologist, has one been consulted on this case?

☐ **Yes** ☐ **No**

Specialist name: _____ Specialist Type: _____

List previous medications/therapies tried and failed for this condition: (include oral and injectable, etc.)

Therapy (and dates)	Reason for discontinuation

Prescriber Additional Comments:

4 PRESCRIPTION

Dosage Form and Quantity:

☐ Kineret 100 mg/0.67 ml prefilled syringe

Dispense Quantity:

☐ 28 syringes

Sig: Dose/Route/Frequency: _____

Refill X: _____

Deliver product to: ☐ Patient's home ☐ MD office ☐ Clinic

Prescriber's Signature: _____ **Date:** _____

Last Updated 12/2014