



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

Complete form in its entirety and fax to number listed below

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PATIENT INFORMATION

Last Name		First Name	Middle Initial
Date of Birth	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Medicaid ID #	
Allergies: <input type="checkbox"/> NKA or _____			
Street Address		City	
State	County	Zip Code	
Home Phone		Cell Phone	
Parent/Guardian		Day Telephone	Night Telephone
Emergency Contact		Relationship	Telephone

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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	



Fax Completed Form to:
Fax Number: 800-218-3221
Phone Number: 866-843-3604

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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:

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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: _____