



# 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<br>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: \_\_\_\_\_