Prescriber Criteria Form Kineret PA 2026 PA Fax 120-A v2 010126.docx Kineret (anakinra) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Kineret (anakinra).

Drug Name: Kineret (anakinra)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Has the patient previously received the requested drug for one of the following conditions: A) rheumatoid arthritis, B) neonatal-onset multisystem inflammatory disease (NOMID), C) deficiency of interleukin-1 receptor antagonist (DIRA), D) systemic juvenile idiopathic arthritis, E) adult-onset Still's disease, F) multicentric Castleman's disease, G) Schnitzler syndrome, H) Erdheim-Chester disease? [If yes, then no further questions.]	Yes	No
2	Is the requested drug prescribed for a patient with neonatal-onset multisystem inflammatory disease (NOMID)? [If yes, then no further questions.]	Yes	No
3	Is the requested drug prescribed for a patient with moderately to severely active rheumatoid arthritis (RA)? [If no, then skip to question 5.]	Yes	No
4	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to two of the following products: A) Enbrel (etanercept), B) Hadlima (adalimumab-bwwd), C) Humira (adalimumab), D) Rinvoq (upadacitinib), E) Tyenne (tocilizumab-aazg), F) Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release)? [No further questions.]	Yes	No

5	Is the requested drug prescribed for a patient with active systemic juvenile idiopathic arthritis (sJIA)? [If no, then skip to question 7.]	Yes	No
6	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to Tyenne (tocilizumab-aazg)? [No further questions.]	Yes	No
7	Is the requested drug prescribed for a patient with deficiency of interleukin-1 receptor antagonist (DIRA)? [If yes, then no further questions.]	Yes	No
8	Is the requested drug prescribed for a patient with adult-onset Still's disease? [If yes, then no further questions.]	Yes	No
9	Is the requested drug prescribed for a patient with multicentric Castleman's disease? [If yes, then no further questions.]	Yes	No
10	Is the requested drug prescribed for a patient with Schnitzler syndrome? [If yes, then no further questions.]	Yes	No
11	Is the requested drug prescribed for a patient with Erdheim-Chester disease?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____