

UPMC HEALTH PLAN

KINERET

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES

PHONE 800-979-UPMC (8762)

FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY

Please complete all sections of this form. Incomplete responses may delay this request.

Office Contact:	Provider Specialty:
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Provider First Name:	Provider Last Name:
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Provider Phone:	Provider Fax:	Provider NPI #:
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Patient Name:	Patient UPMC Health Plan ID Number:	Patient DOB:
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Drug Requested:	Strength:	Frequency:	Qty Dispensed:	Patient Age:
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Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

<input type="checkbox"/> New medication	If ongoing, provide date started:	If medication is ongoing, Did the member show improvement while on therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Please indicate place of administration / infusion:	<input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital/Facility	Please indicate how medication will be billed:
Please provide facility/provider name and address:		<input type="checkbox"/> Billed directly by the provider via JCODE Provide JCODE: _____
		<input type="checkbox"/> Billed by a pharmacy and delivered to the provider
		<input type="checkbox"/> Billed by a pharmacy and delivered to the patient

Please complete the following questions.

Does the member have a diagnosis of moderate to severely active rheumatoid arthritis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, please list diagnosis:	

Is there evidence of Infection? Yes No

Is the member currently using another TNF-blocking agent or biologic agent in combination with Kineret? If yes, please indicate drug name:	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Has the member tried and failed Methotrexate for at least 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Please indicate dates of therapy and dose:

Please indicate reason for discontinuation:

Please indicate if the member tried and failed any of the following for at least 3 months?

Leflunomide (Arava) Minocycline (Minocin) Sulfasalazine (Azulfidine) Hydroxychlorquine (Plaquenil)

Please provide dates of therapy and dose:

Reason for discontinuation:

Please indicate if the member tried and failed any of the following TNF blocking agents for at least 3 months?

Enbrel Remicade Cimzia Humira Simponi

Please indicate dates of therapy and dose:

Please indicate reason for discontinuation:

Please provide any additional information which should be considered in the space below:

