South Dakota Department of Social Services

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
Mon-Sat: 7am to 7pm Central

Kineret® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			**Provider Information** (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand** ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Cryopyrin-associated periodic syndromes (CAPS)
❑ Moderately to severely active rheumatoid arthritis (RA)
❑ Deficiency of interleukin-1 receptor antagonist (DIRA)
❑ Other diagnosis: ____ ICD-10 Code(s): ______________________________

Clinical information:

Select if the requested medication is prescribed by or in consultation with one of the following specialists:
❑ Allergist/ Immunologist ❑ Dermatologist ❑ Gastroenterologist ❑ Neurologist ❑ Rheumatologist
❑ Other ______________________________

Will the requested medication be used in combination with another biologic agent? ❑ **Yes** ❑ **No**

For moderately to severely active rheumatoid arthritis (RA), also answer the following:

Has the patient had an inadequate response to, intolerance to, or contraindication to one or more non-biologic disease modifying anti-rheumatic drugs (DMARDs)? ❑ **Yes** ❑ **No** List ____

Quantity limit requests:

What is the quantity requested per TREATMENT? ______ syringe every ______ weeks

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: ____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.

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