



# PRIOR AUTHORIZATION PROGRAM FORM

## Kineret® ( Anakinra )

### Instructions:

- Section 1 to be completed by Plan Member / Patient
- Section 2 to be completed by Physician (expenses incurred by the completion of this form is at plan member's expense)
- Section 3 to be completed by Pharmacist

Please fax completed form to NexgenRx Formulary Management to 1-877-639-4369 or mail to 145 The West Mall P.O. Box 110 U, Toronto, Ontario, M8Z-5M4

### Section 1: To be completed by Patient

Member's Name: (Last, First)	Card ID Number:																		
Patient's Name: (Last, First)	Patient's Date of Birth (dd/mm/yy)	Relationship to Member (please circle)			PATIENT CODE														
		Employee	Spouse	Dependent															

### Results of this request to be communicated to:

<input type="checkbox"/> Pharmacy	<input type="checkbox"/> Patient / Legal Guardian Named Below	<input type="checkbox"/> email:
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I authorize NexgenRx Inc. (a) to use the personal information disclosed on this form, and any other personal information known to NexgenRx Inc. regarding the above-named patient, for the purpose of assessing this prior authorization request and any related claim and administering the benefit plan under which any such claim is made, and (b) to contact, and to obtain any such personal information from and to disclose any such personal information to, any physician, pharmacist or other health care professional having knowledge of such patient's health relevant to this request and any related claim.

Patient / Legal Guardian Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Signature of Patient/ Legal Guardian: \_\_\_\_\_ Date (dd/mm/yy): \_\_\_\_\_

### Section 2: To be completed by Physician

Drug Name & Strength: KINERET 100 MG/0.67 ML SYRINGE	DIN: 02245913	Dosage Instructions:
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Eligibility for drug coverage is dependent upon the patient meeting at least one of the qualifying criteria listed below. If the patient has another drug plan, prior authorization may cover some or all of the excess not paid by the primary plan.

Please indicate if the patient meets at least one of the following qualifying criteria for drug coverage:

- To reduce the signs of moderate to severe active rheumatoid arthritis in adult patients.
- To inhibit the progression of structural damage by reducing erosions and cartilage degradation in patients with active rheumatoid arthritis despite stable doses of methotrexate.

Physician Name: (Last, First)	License Number:
Address: (Street, City, Province, Postal Code)	Telephone Number : ( ) -
	Fax Number: ( ) -
Signature of Physician:	Date (dd/mm/yy)

### Section 3: To be completed by Pharmacist

Pharmacy Name:	Provider Number:
Pharmacy Address: (Street, City, Province, Postal Code)	Telephone Number : ( ) -
	Fax Number: ( ) -
Signature of Pharmacist: _____	
Pharmacist's Name: (Print Last, First) _____	

### Internal Office Use Only:

Date Received:		Date Approved & By:
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