



TEXAS MEDICAID Clinical Edit Prior Authorization anakinra (KINERET)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING

Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

STEP 2: MEDICATION INFORMATION

Medication Requested (Name):	Quantity Requested:
Dose Requested:	Dosing Instructions:

Patient's Primary Diagnosis: _____ ICD 10 Code: _____

Please indicate ONE (1) of the following:

STAR / STAR KIDS client (**Go to Step 3 - PDL PA Criteria Applies**)

OR CHIP / PERINATE client (**Go to Step 4**)

STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT

1. Has the client failed a 30-day treatment trial with at least one (1) preferred agent in the last 180 days?

Yes (Go to Step 4 Question 1)

No (Go to #2)

2. Is there a documented allergy or contraindication to preferred agents in this class?

Yes (Go to Step 4 Question 1)

No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

Yes (Go to Step 4 Question 1)

No (Deny)



STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Does the client have a diagnosis of Rheumatoid Arthritis (RA) in the last 730 days?

Yes (Go to #2)

No (Go to #5)

2. Is the client greater than or equal to (\geq) 18 years of age?

Yes (Go to #3)

No (Deny)

3. Does the client have one (1) claim for a disease modifying anti-rheumatic drug (DMARD) in the last 180 days?

Examples of DMARDs include azathioprine (IMURAN), cyclosporine (GENGRAF, NEORAL, SANDIMMUNE), hydroxychloroquine (PLAQUENIL), leflunomide (ARAVA), methotrexate (OTREXUP, TREXALL, XATMEP), and sulfasalazine (AZULFIDINE).

Yes (Go to #6)

No (Go to #4)

4. Does the client have a contraindication to or is the client non-responsive to DMARDs? [Manual Step]

Yes (Go to #6)

No (Deny)

5. Does the client have a diagnosis of Cryopyrin-Associated Periodic Syndrome (CAPS) or Deficiency of Interleukin-1 Receptor Antagonist (DIRA) in in the last 730 days?

Yes (Go to #6)

No (Deny)

6. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

Yes (Deny)

No (Go to #7)

7. Does the client have one (1) claim for a tumor necrosis factor (TNF)-blocker in the last 30 days?
Examples of TNF-blockers include CIMZIA, ENBREL, HUMIRA, and SIMPONI.

Yes (Deny)

No (Approve – 365 days)

STEP 5: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: 855-668-8553

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.