Drug Coverage Review Request

Kineret ®

SUPPLY ALL PRESCRIBER AND PATIENT INFORMATION

PRESCRIBER		**PATIENT**	
MD First Name		Cardholder ID #	
MD Last Name		Patient Last Name	
Address		Patient First Name	
City		Date of Birth	
State		Address	
Zip Code		City	
Phone		State	
Fax		Zip Code	
DEA number (*optional*)		Phone	

Your patient's benefit plan requires that we review certain requests for coverage with the prescribing physician. This includes requests for benefit coverage beyond plan specifications. Please complete the following questions and then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the benefit plan's rules.

SECTION A Please answer the following questions

1. ☐ Yes ☐ No Will the patient be receiving MORE THAN ONE biologic rheumatoid arthritis agent (*Enbrel, Kineret, Humira, Remicade, Orencia* or *Rituxan*) AT THE SAME TIME?
2. ☐ Yes ☐ No Is the patient CURRENTLY RECEIVING this drug for the treatment of rheumatoid arthritis?
3. ☐ Yes ☐ No ☐ Not Applicable If **Yes** to the **previous question**, has drug therapy provided SIGNIFICANT IMPROVEMENT in the patient's condition?
4. ☐ Yes ☐ No Is this drug being prescribed for the treatment of moderately to severely active rheumatoid arthritis?
5. ☐ Yes ☐ No Is the patient CURRENTLY RECEIVING methotrexate?
6. ☐ Yes ☐ No If the patient is not currently receiving methotrexate, has previous use of methotrexate FAILED TO TREAT this patient's condition?
7. ☐ Yes ☐ No Is the patient a CANDIDATE FOR RECEIVING methotrexate?

SECTION B Physician Signature

PHYSICIAN SIGNATURE

DATE

FAX COMPLETED FORM TO: 1 800 837-0959

PLEASE DO NOT FAX WITH A COVER SHEET

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