



Date _____

Client _____

PRIOR AUTH QUESTIONNAIRE- KINERET®

<i>M.D. Last Name:</i> _____	<i>M.D. First Name:</i> _____
<i>Physician Phone:</i> _____	<i>Physician Fax:</i> _____
<i>Patient</i> _____	<i>ID#</i> _____ <i>DOB</i> _____

TO ENSURE PROMPT PROCESSING PLEASE COMPLETE ALL OF THE QUESTIONS.

PLEASE NOTE: FOR ALL REQUESTS, PLEASE ATTACH THE MOST RECENT COPY OF THE PATIENT'S PROGRESS NOTES

1. Please indicate patient's diagnosis:

Moderate-to-severe Rheumatoid Arthritis

*Other diagnosis: _____

*Note: If Other diagnosis is used, please attach a study with efficacy data supporting this request

2. List dates, and attach chart notes to document member's failure on a DMARD:

DMARD Used/Failed: _____

Dates used: _____

3. Patient is diagnosed with hypersensitivity to E. coli-derived proteins, anakinra or any component of anakinra? Yes No

4. Does the patient have an injection, including chronic or a local infection? Yes No

Physician Signature or name of person providing answers _____

Physician Comments _____

Send or Fax completed form to:

877-329-7279

RESTAT
P.O. BOX 758
WEST BEND, WI 53095

www.restat.com

QUESTIONS PLEASE CALL:

877-526-9906

If approvable, open-ended prior authorization will be given to members.

For tech use ONLY: Kineret Max Daily Dose = 0.67