



Date _____

Client _____

PRIOR AUTH QUESTIONNAIRE - ORENCIA®

M.D. Last Name: _____	M.D. First Name: _____
Physician Phone: _____	Physician Fax: _____
Patient _____	ID# _____ DOB _____

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. Is the patient 18 years old or older? Yes No
- 2. Please indicate patient's diagnosis:
 - Moderate to severely active Rheumatoid Arthritis
 - Other* _____

***Note: If "Other" diagnosis is used, please attach a study with efficacy data supporting this request**
- 3. List a DMARD or DMARD's that the member has tried and failed and dates used:

- 4. If another anti-TNF is being used, will it be discontinued? Yes No
- 5. If Kineret® (anakinra) is being used, will it be discontinued? Yes No
- 6. Patient Weight: (Kg): _____ Dose requested (mg): _____
- 7. Frequency (how often given in weeks): _____
- 8. Does the patient have COPD? Yes No
- 9. If YES, will the patient be monitored for worsening of their respiratory status? Yes No
- 10. Does the patient have a clinically important infection? Yes No
- 11. Has the patient had a TB test? Yes No
- 12. Will the patient be given the Patient Information leaflet each time prior to treatment? Yes No
- 13. Has the patient been vaccinated in the past three months? 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

QUESTIONS PLEASE CALL:
877-526-9906