



### Physician's Prior Authorization Questionnaire for Kineret®

PATIENT'S NAME: \_\_\_\_\_ ID#: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Kineret® is covered under certain clinical conditions. Please furnish the information below to assist us in making a determination of this patient's eligibility for coverage for treatment with this drug.

1. What is the patient's diagnosis (no codes please)? \_\_\_\_\_

2. How old is the patient? \_\_\_\_\_

3. If rheumatoid arthritis, is the patient experiencing moderate to severe active disease? \_\_\_YES \_\_\_NO

4. Has the patient failed previous therapy? \_\_\_YES \_\_\_NO

5. If Yes to question 4, please list the medications: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

6. Will this medication be used in combination with anti-TNF alpha medications? \_\_\_YES \_\_\_NO

**For Systemic Onset Juvenile Rheumatoid Arthritis or Neonatal Onset Juvenile Inflammatory Disease,  
please submit medical records outlining the patient's condition.**

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please **Print** Name

\_\_\_\_\_  
Fax Number

\_\_\_\_\_  
Please **Print** Physician's Specialty

\_\_\_\_\_  
Phone Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact ABCBS at (501) 378-3392. For your convenience, you may fax your response(s) back to ABCBS at (501) 378-6980.

Sincerely,  
Pharmacy Programs

Forms are also available online at <http://usableadmin.abcbs.net/providers/PharmacyForms.aspx>