

KINERET® DISEASE MODIFYING ANTIRHEUMATIC DRUG PRIOR REVIEW FAXBACK FORM

PROVIDER INFORMATION		PATIENT INFORMATION
PHYSICIAN NAME	PROVIDER ID/TAX ID	PATIENT NAME
CONTACT PERSON		PATIENT'S BCBSNC ID
PHONE	FAX	PATIENT'S DATE OF BIRTH

1. Does the patient have a diagnosis of Rheumatoid Arthritis?..... Yes No

2. Is the patient at least 18 years of age?..... Yes No

3. Has the patient experienced a therapeutic failure/
inadequate response with Methotrexate? Yes No

4. Is Methotrexate contraindicated? Yes No

5. Is the patient being treated for rapidly progressive and advancing disease? Yes No

6. Other Pertinent Information: _____

I certify, that to the best of my knowledge, the information above is accurate.

Prescriber's Signature Required: _____

Fax completed form to 1-800-795-9403

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