



ANAKINRA (KINERET®)
PRIOR REVIEW/CERTIFICATION FAXBACK FORM

INCOMPLETE FORMS MAY DELAY PROCESSING
ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT BCBSNC PROVIDER ID# BELOW

PRESCRIBER INFORMATION		PATIENT INFORMATION
PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH
PRACTICE ADDRESS	CITY	STATE
		ZIP

Please answer the following questions: **Dx Code:** _____

- Does the patient have a diagnosis of Rheumatoid Arthritis? Yes No
- Is the patient at least 18 years of age? Yes No
- Has the patient experienced a therapeutic failure/inadequate response with Methotrexate? Yes No
- Is Methotrexate contraindicated? Yes No
- Is the patient being treated for rapidly progressive and advancing disease? Yes No

Please certify the following by signing and dating below:

I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required): _____ Date: _____

For BCBSNC members, fax form to 1-800-795-9403