

Please provide the following information by fax or phone. Upon receipt, a reimbursement counselor will research the patient's current benefits for Kineret®, complete a *Coverage Profile Report* and contact the patient regarding their current benefits for Kineret® as appropriate.

Please indicate who should receive the *Coverage Profile Report*.

Patient

Provider

Both

PROVIDER INFORMATION

Name _____
 Specialty _____
 Tax ID # _____
 Payer Specific Provider # _____
 Site Name _____
 Address _____
 City _____
 State _____ Zip _____
 Phone _____ Fax _____
 Office Contact _____
 Best time to call _____

PATIENT INFORMATION

Name _____
 Address _____
 City _____
 State _____ Zip _____
 Day Phone _____
 Evening Phone _____
 Best time to call _____
 SS# _____ DOB _____

PATIENT INSURANCE INFORMATION

Insurance Company Name (1) _____
 Phone _____
 Policy # _____ Group # _____
Policy Holder Information (if different from patient):
 Name _____
 Employer _____ SS# _____
 Relation to Patient _____
 Insurance Company Name (2) _____
 Phone _____
 Policy # _____ Group # _____
Policy Holder Information (if different from patient):
 Name _____
 Employer _____ SS# _____
 Relation to Patient _____

PATIENT MEDICAL HISTORY

Diagnosis /ICD-9-CM code _____
 Is diagnosis consistent with ACR guidelines? _____
 Date of diagnosis or Years with disease _____
 Number of swollen joints _____
 Number of tender/painful joints _____
 Duration of morning stiffness _____
 What is ESR (__ mm/hr)? _____
 What is CRP (__ mg/dL)? _____

Treatment History

<i>Past</i>	<i>Current</i>	<i>DMARDs</i>	<i>Length of treatment</i>
<input type="checkbox"/>	<input type="checkbox"/>	Methotrexate	
<input type="checkbox"/>	<input type="checkbox"/>	Azathioprine	
<input type="checkbox"/>	<input type="checkbox"/>	Cyclosporine	
<input type="checkbox"/>	<input type="checkbox"/>	Gold Compounds	
<input type="checkbox"/>	<input type="checkbox"/>	Hydroxychloroquine	
<input type="checkbox"/>	<input type="checkbox"/>	Leflunomide	
<input type="checkbox"/>	<input type="checkbox"/>	Sulfasalazine	
<input type="checkbox"/>	<input type="checkbox"/>	Etanercept	
<input type="checkbox"/>	<input type="checkbox"/>	Infliximab	
<input type="checkbox"/>	<input type="checkbox"/>	(other)	
<input type="checkbox"/>	<input type="checkbox"/>	Prednisone, dose range _____	
<input type="checkbox"/>	<input type="checkbox"/>	NSAID, COX2 or analgesic	

Prescribed Dose & Frequency of Kineret™ _____

PATIENT CONSENT

Benefit Verification Requested by Patient:

The Kineret® Reimbursement Hotline must have your consent to contact your insurance company to conduct benefit research. If we have your consent, please sign below.

Patient's Signature _____

OR

Benefit Verification Requested by Physician:

The Kineret® Reimbursement Connection must have your patient's consent to share this medical information. If you have the patient's consent to release this information on file, please sign below.

Physician Representative Signature _____