SWEDISH ORPHAN BIOVITRUM

Kineret Reimbursement Hotline
Phone 866-547-0644
Fax 866-549-7219

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 Benefit Investigation Report and contact the appropriate party regarding current benefits for Kineret.

Please indicate below, who should receive a copy of the Benefit Investigation Report

☐ Patient ☐ Provider ☐ Both

PROVIDER INFORMATION

Name ______
Specialty ______
Tax ID# ______
NPI # ______
DEA # ______
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

Primary Ins. ______
Phone ______
Policy# ______ Group# ______
Policy Holder Information ______
Name ______
Employer ______ SS# ______
Relation to Patient ______
Secondary Ins. ______
Phone ______
Policy# ______ Group# ______
Policy Holder Information ______
Name ______
Employer ______ SS# ______
Relation to Patient ______

PATIENT MEDICAL HISTORY

ICD-9 Code ______
Is Diagnosis Consistent with ACR Guidelines? ______
Date of Diagnosis or Years with Disease ______
Number of Swollen Joints ______
Duration of Morning Stiffness ______
What is ESR (__mm/hr)? ______
What is CRP (__mg/dL)? ______

TREATEMENT HISTORY

Past	Current	DMARDs	Length of Treatment
☐	☐	Methotrexate	
☐	☐	Azathioprine	
☐	☐	Cyclosporine	
☐	☐	Gold Compounds	
☐	☐	Hydroxychloroquine	
☐	☐	Leflunomide	
☐	☐	Sulfasalazine	
☐	☐	Etanercept	
☐	☐	Infliximab	
☐	☐	Other	
☐	☐	Prednisone, Dose Range	
☐	☐	NSAID, COX2, 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

______

Benefit Verification Requested by Physician

The Kineret Reimbursement Hotline 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

Healthcare Provider Signature

______