



## Neonatal Onset: Multi-System Inflammatory Disease - (Kineret)

### Beneficiary Information

1. Beneficiary Last Name: \_\_\_\_\_ 2. First Name: \_\_\_\_\_  
3. Beneficiary ID #: \_\_\_\_\_ 4. Beneficiary Date of Birth: \_\_\_\_\_ 5. Recipient Gender: \_\_\_\_\_

### Prescriber Information

6. Prescribing Provider NPI#: \_\_\_\_\_  
7. Requester Contact Information - Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Ext: \_\_\_\_\_

### Drug Information

8. Med requested: \_\_\_\_\_ 9a. Strength \_\_\_\_\_ 9b. Quantity per 30 days \_\_\_\_\_ 9c. Duration \_\_\_\_\_  
10. Does the beneficiary have a diagnosis of Neonatal Onset: Multi-System Inflammatory Disease?  
**YES** \_\_\_ **NO** \_\_\_  
11. Is the beneficiary on any other injectable immunomodulator? **YES** \_\_\_ **NO** \_\_\_  
12. Has the beneficiary been screened for latent tuberculosis infection? **YES** \_\_\_ **NO** \_\_\_  
13. Has the beneficiary been tested with Hep B SAG and Core Ab? **YES** \_\_\_ **NO** \_\_\_  
Date of lab and result \_\_\_\_\_

Signature of Prescriber: \_\_\_\_\_ Date: \_\_\_\_\_  
**(Prescriber signature mandatory)**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

**Fax this form to: (800) 678-3189**

**Pharmacy PA Call Center: (866) 799-5318**