Immunomodulators - Cryopyrin-Associated Periodic Syndromes (CAPS) including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS): Arcalyst and Ilaris

Member Information

1. Last Name: ____ 2. First Name: _________________________________
3. Trillium ID #: __________________________ 4. Date of Birth: _________________________ 5. Gender: _________

Prescriber Information

1. Prescriber Name: ____ 2. NPI #: _____________________________
3. Requestor Name (Nurse/Office Staff): ____
4. Mailing Address: ____ City: _________________ State: ____ Zip: _____
5. Phone #: ___________________________________ Ext. ________ Fax #: ___________________________________

Drug Information

1. Drug Name: _____________________ 2. Strength: ____________________ 3. Quantity per 30 Days: ______________
   Length of Therapy (in Days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days ☐ Other: _________

Clinical Information

1. Does the member have a diagnosis of Cryopyrin-Associated Periodic Syndromes including Familial Cold Autoinflammatory Syndrome and Muckle-Wells Syndrome? ☐ **Yes** ☐ **No**

2. Is the member on any other injectable Immunomodulator? ☐ **Yes** ☐ **No**

3. Has the member been screened for latent tuberculosis infection? ☐ **Yes** ☐ **No**

4. Has the member been tested with Hep B SAG and Core Ab? ☐ **Yes** ☐ **No**

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 PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277