

Immunomodulators - Hyperimmunoglobulin D Syndrome (HIDS) /Mevalonate Kinase Deficiency (MKD): 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: Ilaris 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 Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD)? **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.