BLUEGRASS PHARMACY | CAPS SYNDROME ENROLLMENT FORM

BLUEGRASS Pharmacy
A Member of the Wellpartner Family

FAX FORM TO: 1.866.233.8317 | **PHONE:** 1.855.492.0817 | **EMAIL:** contact@bluegrass-rx.com

Complete the following or include demographic sheet.

1. PATIENT INFORMATION

Name:

Address:

City, State, ZIP:

Primary Phone: - - DOB: / /

Alternate Phone: - - Gender:

Email:

Primary Language: Last Four of SSN:

2. PRESCRIBER INFORMATION

Name:

DEA #: NPI #: State Lic. #:

Group or Hospital:

Address:

City, State, Zip:

Phone: - - Fax: - -

Contact Person: Phone: - -

3. INSURANCE INFORMATION

*Fax copy of **prescription** and **insurance cards** with this form, if available (front and back)*

Primary Insurance Company Name:

Primary Cardholder Name:

Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent

Phone: - - Member ID: Group #:

Secondary Insurance Company Name:

Secondary Cardholder Name:

Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent

Phone: - - Member ID: Group #:

4. DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: / / Ship to: ◯ Patient ◯ Office ◯ Other:

Date of Diagnosis: / /

◯ E85.Ø Non-neuropathic heredofamilial amyloidosis

◯ L5Ø.2 Urticaria due to cold and heat

◯ Other:

Height (in/cm):

Weight (lb/kg):

Specialty pharmacy to coordinate injection training/home health care nurse visit:

◯ Yes ◯ No ◯ Injection training is not necessary

If no, reason:

◯ MD office trained patient ◯ Patient already independent ◯ Referred by MD to alternate trainer

Allergies:

Concomitant medications:

5. PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
◯ Arcalyst®	◯ 160 mg ◯ _____ mg	◯ Weekly subcutaneous injection. ◯ Other:	_____ Vials	
◯ Ilaris®	◯ Check box if: BW ≥ 15 kg to ≤ 40 kg dose = _____ kg x 2 mg/kg 3 mg/kg = _____ mg ◯ Check box if: BW > 40 kg dose = 150 mg ◯ _____ mg	◯ Every 8 weeks subcutaneous injection. ◯ Other:	_____ Vials	
◯				
◯				

Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE

X / /

DISPENSE AS WRITTEN DATE

X / /

PRODUCT SUBSTITUTION PERMITTED DATE