

FAX FORM TO: 1.877.597.3070

PHONE: 1.800.473.3516

EMAIL: specialty@wellpartner.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		<i>Fax copy of prescription and insurance cards with this form, if available (front and back)</i>	
Primary Insurance Company Name:		Secondary Insurance Company Name:	
Primary Cardholder Name:		Secondary Cardholder Name:	
Relationship: <input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child/Dependent		Relationship: <input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child/Dependent	
Phone: - -	Member ID:	Group #:	Phone: - -
			Member ID:
			Group #:

4. DIAGNOSIS AND CLINICAL INFORMATION	
Needs by Date: / /	Ship to: <input type="radio"/> Patient <input type="radio"/> Office <input type="radio"/> Other:
Date of Diagnosis: / /	Specialty pharmacy to coordinate injection training/home health care nurse visit:
<input type="radio"/> E85.0 Non-neuropathic hereditary familial amyloidosis	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Injection training is not necessary
<input type="radio"/> L50.2 Urticaria due to cold and heat	If no, reason:
<input type="radio"/> Other:	<input type="radio"/> MD office trained patient <input type="radio"/> Patient already independent <input type="radio"/> Referred by MD to alternate trainer
Height (in/cm):	Allergies:
Weight (lb/kg):	Concomitant medications:

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

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

6. PRESCRIBER SIGNATURE	
X _____ / /	X _____ / /
DISPENSE AS WRITTEN	DATE
PRODUCT SUBSTITUTION PERMITTED	DATE

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address or telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.