

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	
<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"/> Yes <input type="radio"/> No <input type="radio"/> Injection training is not necessary
<input type="radio"/> E85.0 Non-neuropathic hereditary familial amyloidosis	If no, reason: <input type="radio"/> MD office trained patient <input type="radio"/> Patient already independent <input type="radio"/> Referred by MD to alternate trainer
<input type="radio"/> L50.2 Urticaria due to cold and heat	Allergies: _____
<input type="radio"/> Other: _____	Concomitant medications: _____
Height (in/cm): _____	
Weight (lb/kg): _____	

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.