## **CAPS Syndrome Enrollment Form**



Fax Referral To: 1-877-232-5455

Phone: 1-808-254-2727 Address: 500 Ala Moana Blvd., Bldg 1 Honolulu, HI 96813 NCPDP: 1203417

Patient Name:	PATIENT IN	FORMATION (C	Complete or include demograph	icsheet)		
Preferred Contact Methods:  Phone (to primary # provided below)  Text (to cell # provided below)  Penelow  Phone (to primary # provided below)  Text (to cell # provided below)  Phone below)  Phone (to primary # providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty" about your prescription(s), account, and health care. St. acts as apply, Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by primary Phone:				DOB:		☐ Male ☐ Female
Note: Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive undornated calls, emails and/or text messages from CVS Specialty* about your prescription(s), account, and health care. States apply. Message frequency varies. If unable to contact via text or email. Specialty Pharmacy will attempt to contact by primary Phone:				City, State, ZIP Code	:	
Acceptable   Acc	eferred Conta	ıct Methods: 📙 Pl	none (to primary # provided below	) L Text (to cell # provi	ded below) 📙 Email	(to email provided
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Alternate Phone:  mail:  Last Four of SSN: Primary Language: arent/Caregiver/Legal Guardian Name (Last, First): Relationship to patient:  PRESCRIBER INFORMATION  rescriber's Name:  DEA #: Group or Hospital: ddress: City, State, ZIP Code: hone: Fax Contact Person: Contact's Phone: INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)  DIAGNOSIS AND CLINICAL INFORMATION leeds by Date: Ship to: Patient Office Other: lagnosis (ICD-10):  MO4.2 Cryopyrin-associated periodic syndromes Other Code: Description Patient Clinical Information:  Illergies: Weight: Ib/kg Height: in/c  PRESCRIPTION INFORMATION  PRESCRIPTION INFORMATION    PRESCRIPTION STRENGTH   DOSE DIRECTIONS   QUANTIT						
mail:Last Four of SSN:Primary Language:						
PRESCRIBER INFORMATION   State License #:   State	nail:		Last Fo	our of SSN: P	 rimary Language:	
PRESCRIBER INFORMATION  rescriber's Name:						
State License #:     State License #:       DEA #:						
PI #: DEA #: Group or Hospital: City, State, ZIP Code: Contact's Phone: Fax Contact Person: Contact's Phone: INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)     Patient   Office   Other:				License#:		
City, State, ZIP Code:						
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PRESCRIPTIONINFORMATION   MEDICATION   STRENGTH   DOSE & DIRECTIONS   QUANTITY	Other Code:	Descriptio	on			
PRESCRIPTIONINFORMATION  MEDICATION STRENGTH DOSE & DIRECTIONS QUANTITY  Please complete an Arcalyst Patient Enrollment and Consent form and indicate CVS Specialty as your preferred pharmacy provider. The form may be accessed at www.kiniksaoneconnect.com or by calling 1-833-KINIKSA (1-833-546-4572).  Fax enrollment form to 781-609-7826.    150 mg SC every 8 weeks (Patients with body weight greater than 40 kg)   2 mg/kg (Dose =mg) SC every 8 weeks for patients with body weight greater than or equal to 15 kg and less than or equal to 40 kg   Other:	atient Clinica	al Information:				
Arcalyst	lergies:			Weight:lb/kg	Height:	in/cm
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Ilaris (Must be administered by healthcare professional.)   150 mg/mL solution in singledose vials   150 mg/mL soluti		solution in single-				
(Must be administered by healthcare professional.)  Patient is interested in patient support programs  To prescriber's Signature:  Dispense with:  1 X 18 G 1.5 inch needle  1 X 27 G 1/2 inch needle  1 X 1 mL syringe  1 X box alcohol swabs  1 X Sharps container  Ancillary supplies and kits provided as needed  Ancillary supplies and kits provided as needed  May Substitute / Product Selection Permitted /  Substitution Permissible  Prescriber's Signature:  Date:  Date:  Dispense with:  1 X 18 G 1.5 inch needle  1 X 27 G 1/2 inch needle  1 X 27 G 1/2 inch needle  1 X 1 mL syringe  1 X box alcohol swabs  1 X Sharps container  Ancillary supplies and kits provided as needed  May Substitute / Product Selection Permitted /  Substitution Permissible  Prescriber's Signature:  Prescriber's Signature:	□ Ilaris		than or equal to 15 kg and less than or equal to 40 kg  Other: Dispense with: 1 X 18 G 1.5 inch needle 1 X 27 G 1/2 inch needle 1 X 1 mL syringe			
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CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" ATTN: New York and Iowa providers, please submit of	Prescriber's S	Signature:	Date:	_ Prescriber's Signat	ture:	Date:
	CA, MA, NC & PR:	Interchange is mandated u	unless Prescriber writes the words "No Substitution	n" ATTN: New \	ork and Iowa providers, ple	ase submit electronic prescrip
he information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing						

hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by tele phone and destroy all copies of this communication and any attachments.

 $Plan\ member\ privacy\ is\ important\ to\ us.\ Our\ employees\ are\ trained\ regarding\ the\ appropriate\ way\ to\ handle\ members'\ private\ he\ alth\ information.$ 

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