ILARIS®

Patient Enrollment & Prescription Form

P: 1-844-443-6879 F: 1-844-329-2447

PATIENT INFORMATION

Patient Name ______________________________

DOB ___/___/______ SSN ________________ Gender______

Weight ________ Height ________ Phone ________________

Address ______________________________

City, State, Zip ______________________________

Cell Phone ______________ E-Mail ________________

PLEASE PROVIDE COPY OF PATIENT'S PRESCRIPTION INSURANCE CARD WITH ENROLLMENT FORM

Insurance Co. Name ______________________________

Insurance Co. Phone ________________ Group# __________

Policy Holder Name ______________________________

Policy Holder Employer ______________________________

Relationship to Patient ______________________________

ID# ________________ RxBIN ____________ PCN__________

PRESCRIBER INFORMATION

Prescriber's Name ______________________________

Practice Name ______________________________

State License#________________ UPIN ____________

DEA ________________ NPI ______________

Address ______________________________

City, State, Zip ______________________________

Phone ______________ Fax ________________

Office Contact Person ______________________________

Prescription Date ______________ Date Needed __________

Prescriber Signature ______________________________

Ship to: ☐ Patient ☐Discount Drug Mart ☐Prescriber's Office

Medical Information

Diagnosis ______________________________ Date of Diagnosis ____________

Patient Weight ______________ ICD-10 Code ________________

Drug Allergies ______________________________

Any other relevant medical info? ______________________________

Lab Results (Serum Amyloid A, C-Reactive Protein, etc.) ______________________________

PRESCRIPTION INFORMATION

☐**ILARIS® 150mg POWDER for Injection** (reconstitute with 1ml of Sterile Water)

Qty (number of vials): ________ Dose: ______________________________

Directions: Adminster subcutaneously every ______ weeks Day Supply ______ Refills ______

SUPPLIES (*Please indicate if supplies are needed)*

☐**Diluent: Sterile water for injection 5ml** Qty ______ Refills ______

☐**1.0-ml syringe for reconsitution** Qty ______ Refills ______

☐**18 g x 2" (50mm) needle for reconstitution** Qty ______ Refills ______

☐**27 G x 0.5" (13mm) needle for administration** Qty ______ Refills ______

☐**Check box if reconstitution supplies are not required**

ADDITIONAL SUPPORTIVE MEDICATION

Medication Name and Dosage Form	Strength	Directions	Qty	Refills

CONFIDENTIALITY NOTICE: THE INFORMATION IN THIS TRANSMITTAL IS CONFIDENTIAL AND INTENDED ONLY FOR THE RECIPIENT LISTED ABOVE. IF YOU ARE NEITHER THE INTENDED RECIPIENT NOR A PERSON RESPONSIBLE FOR DELIVERING THIS TRANSMITTAL TO THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISTRIBUTION OR COPYING OF THIS TRANSMITTAL IS PROHIBITED. IF YOU RECEIVE THIS TRANSMITTAL IN ERROR, PLEASE IMMEDIATELY NOTIFY US AND RETURN THE TRANSMITTAL TO US AT OUR EXPENSE.