CAPS Syndrome
REFERRAL FORM

FAX REFERRAL TO: +1(844) 277-0049 **PHONE: +1(844) 650-5802**

1 PATIENTS INFORMATION *(Complete or include demographic sheet)*

Patient Name: ______ **DOB:** ______ **Gender:** ☐ MALE ☐ FEMALE
Address: ______ **City/State/Zip:** ______
Primary Phone: ______ **Email:** ______ **SSN:** ______ **Primary Language:** ______
Emergency Contact: ______ **Relationship to Patient:** ______ **Phone:** ______

2 INSURANCE *(Please attach **If Available** a copy of the Patients' insurance card(s) Front/ Back)*

Primary Insurance: ______ **Policy No:** ______ **Group:** ______
Primary RX Insurance:______ **ID No:**______ **RX GRP:**______ **RX BIN:**______ **RX PCN:**______

3 DIAGNOSIS AND CLINICAL INFORMATION

Diagnosis (ICD-10):

☐ M04.2 Cryopyrin-associated periodic syndromes
☐ M04.0 Periodic fever syndromes
☐ Other Code: ______ Description ______

Patient Clinical Information:

Drug Allergies:______ NKDA **Ht:** ______in/cm **Wt:** ______lbs/Kg

Current maintenance COPD medications: ______

Tried and failed maintenance COPD medications: ______

4 PRESCRIPTION INFORMATION

ACCESS: ☒ **SUBCUTANEOUS**

MEDICATION	STRENGTH	DOSING & DIRECTIONS	QUANTITY	REFILLS
☐ **Arcalyst**	220 mg	☐ **Loading Dose** (≥18 yrs): Administer 320 mg subcutaneously. (two 160 mg/2 mL injections at different injection sites).	**4 Vials**	**0**
		☐ **Maintenance Dose** (≥18 yrs): 160 mg (2 mL) subcutaneously weekly.	**Qty:** ____	**(x1) Year**
		☐ **Loading Dose** (12-17 yrs): Administer ______ mL *(4.4 mg/kg)* subcutaneously (1-2 injections; ≤2 mL/injection). ***Do not exceed 320 mg (4 mL)***.	**Qty:** ____	**0**
		☐ **Maintenance Dose** (12-17 yrs): Administer ____ mL *(2.2 mg/kg)* subcutaneously weekly (≤2 mL/injection). ***Do not exceed 160 mg (2 mL)***.	**Qty:** ____	**(x1) Year**
		☐ **Maintenance Dose** (patient weight ≥10 kg): Administer ____ mL *(4.4 mg/kg)* subcutaneously weekly (1-2 injections; ≤2 mL/injection). ***Do not exceed 320 mg (4 mL).***	**Qty:** ____	**(x1) Year**
☐ **Ilaris**	150 mg/mL	☐ Administer 150 mg subcutaneously every 8 weeks (Patients with body weight greater than 40 kg). ☐ Administer 2 mg/kg (Dose = ____mg) subcutaneously every 8 weeks for patients with body weight greater than or equal to 15 kg and less than or equal to 40 kg	**Qty:** ____	**(x1) Year**

ANAPHYLAXIS PROTOCOL:

MEDICATION	DIRECTION	QUANTITY	REFILLS
☐ EPINEPHRINE **(autoinjector)**	Administer IM for severe anaphylactic reaction. May repeat in 5-15 minutes ☐ *0.3 mg (Wt > 30 kg)* ☐ *0.15 mg (Wt 15-30 kg)* ☐ *0.1 mg (Wt 7.5-15 kg)*	Quantity: **(x2) Pen(s)**	Refills: **PRN**

NURSING/ LABS/ INFUSION SUPPLIES:

☐ **NURSING:** Nursing visits with each infusion to establish venous access, administer medication, assess and monitor patient, provide education, and complete lab draws.
☐ **INFUSION SUPPLIES:** Infusion supplies and infusion pump PRN for the administration and disposal of medication.

5 PRESCRIBER SIGNATURE REQUIRED *(STAMP SIGNATURE NOT ALLOWED)*

Prescriber Name: ______ **Title:** ☐MD ☐DO ☐ND ☐PA ☐APRN **NPI:** ______
Address: ______ **City/State/ZIp:** ______
Phone: ______ **Fax:** ______ **Contact Person:** ______

☐ DISPENSE AS WRITTEN ☐ BRAND MEDICALLY NECESSARY ☐ DO NOT SUBSTITUTE ☐ NO SUBSTITUTION / ☐ DAW / ☐ MAY NOT SUBSTITUTE **Prescriber's Signature:** ______ **Date:** ______	☐ May Substitute / ☐ Product Selection Permitted / ☐ Substitution Permissible **Prescriber's Signature:** ______ **Date:** ______

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution." NY & IA: electronic prescription required.

Prescribers are to comply with state-specific prescription regulations, which may include requirements for electronic prescribing, generic substitution, authorized prescription formats, and fax language. Noncompliance with these requirements may prompt follow-up communication with the prescriber.

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. I authorize IV Solutions RX and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future refills of the same prescription for the patient listed above. I understand that I can revoke the designation at any time by providing written notice to IV Solutions RX.

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