

Complete Patient and Physician information (PLEASE PRINT)

STEP
1

Member Name:	Physician Name:
Address:	Address:
Member ID:	Phone #:
Member DOB:	Fax #:

If Applicable: Pharmacy Name: _____
Pharmacy Phone: _____

Complete the Clinical Assessment:

Please attach all relevant medical records and test results

STEP
2

Diagnosis	<input type="checkbox"/> Cryopyrin Associated Periodic Syndromes <input type="checkbox"/> Familial Cold Auto-inflammatory Syndrome (FCAS) <input type="checkbox"/> Muckle Wells Syndrome (MWS) <input type="checkbox"/> Neonatal Onset Multisystem Inflammatory Disease (NOMID)	<input type="checkbox"/> Other (please list): _____
Clinical Considerations	Please attach clinical documentation of the following: <input type="checkbox"/> Chart notes citing symptomatology consistent with the indicated diagnosis <input type="checkbox"/> Genetic mutation of CIAS1/NLRP-3 gene <input type="checkbox"/> Patient must be ≥ 12 years of age	
Physician Specialty	_____	
Supporting Documentation Included <input type="checkbox"/>	Diagnosis: ICD-9 Code #/ Description (required):	
	Please attach a copy of the prescription or provide ALL of the information below: Arcalyst (rilonacept) Strength _____ Sig _____ Qty _____ Refills _____	
Incomplete forms will not be processed.		

STEP
3

I certify that the above is correct and accurate to the best of my knowledge (please sign and date).

Prescriber Signature Date

STEP
4

Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk:

970-248-5034

Pharmacy Technician initials _____ Date Initiated _____

Confidentiality Notice:

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