NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

WellCare
Beyond Healthcare. A Better You.

Cryopyrin-Associated Periodic Syndromes - (Kineret)

Beneficiary Information

1. Beneficiary Last Name:_____ 2. First Name:_____

3. Beneficiary ID #:_____ 4. Beneficiary Date of Birth: _____5. Recipient Gender: _____

Prescriber Information

6. Prescribing Provider NPI#:_____

7. Requester Contact Name: _____ Phone #: _____ Ext: _____

Drug Information

8. Medication requested _____

9a. Strength: _____ 9b. Quantity per 30 days: _____ 9c. Duration: _____

10. Does the beneficiary have a diagnosis of neonatal-onset multisystem inflammatory disease or Cyropyrin-Associated Periodic Syndromes? **YES**___ **NO**____

11. Is the beneficiary on any other injectable immunomodulator? **YES**___ **NO**___

12. Has the beneficiary been screened for latent tuberculosis infection? **YES**___ **NO**___

13. Has the beneficiary been tested with Hep B SAG and Core Ab? **YES**___ **NO**____

Date of lab and result**:** _____

_____

Signature of Prescriber: _____ Date: _____

(Prescriber signature mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: **(800) 678-3189** Pharmacy PA Call Center: **(866) 799-5318**