PRESCRIPTION FORM

ARCALYST™ (rilonacept) Resource Center (ARC)

Please complete the following information to start the enrollment process for the ARCALYST Resource Center. If you have any questions regarding the form or the program, please call a Case Manager at 1-877-REGN-777 (1-877-734-6777), select option 4 for assistance.

PATIENT INFORMATION

Name:		
Address:		
Suite/Apt:		
City:	State:	Zip Code:
Phone:	Work:	Mobile:
Date of Birth:	Gender: ☐ Female ☐ Male	

PHYSICIAN INFORMATION

Name:		
Address:		
City:	State:	Zip Code:
Phone:	Fax:	Office Contact:
License #:	Tax ID #:	NPI #:
Medicaid Number:	DEA Number:	

INSURANCE INFORMATION
Please provide a copy of patient's insurance card front& back if available.

Primary Insurance Name:			
Subscriber Name:	Policy #:	Group #	Employer:
Relationship to Patient: ☐ Self ☐ Spouse ☐ Child			
Secondary Insurance Name:			
Subscriber Name:	Policy #:	Group #	Employer:
Relationship to Patient: ☐ Self ☐ Spouse ☐ Child			

MEDICAL INFORMATION

Diagnosis:	ICD-9 Code:

Is this patient an ARCALYST Clinical Trial Patient? ☐ Yes ☐ No
Has the patient been treated with another Interleukin-1 blocker in the last 30 days? ☐ Yes ☐ No

The ARCALYST Resource Center (ARC) is committed to protecting the confidentiality of individuals' health and financial information. The ARC receives health information from health care providers, health plans, and health insurers pursuant to written authorizations from patients with prescriptions for ARCALYST who have enrolled in the ARC program. Program participants also provide ARC with financial information. The ARC uses patients' health and financial information only to provide coverage and reimbursement, care coordination, and support services and for other purposes required by law. The ARC does not share program participants' medical and financial records with Regeneron.
This facsimile contains personal healthcare information from the ARCALYST Resource Center and should only be viewed by the individual to whom it is addressed. Please contact the ARCALYST Resource Center at 1.877.REGN.777 (1-877-734-6777), select option 4 if you have received this transmission in error or have any other questions.

APS-0024-O-02.09 02/08

Prescription: Please refer to the enclosed Recommended Dosage and Administration Instruction Sheet and the ARCALYST™ (rilonacept) Injection for Subcutaneous Use full Prescribing Information for dosage and administration guidelines.

PRESCRIPTION FORM

Product Name: ARCALYST (rilonacept) for Subcutaneous Injection		
# of Days:	Refills:	Directions:
☐ **I request inclusion of the ancillary supplies listed below, which are needed to administer ARCALYST. The ancillary supplies will be sent to patients with their ARCALYST drug product and are included in the cost of the drug.** **Certain state laws require the physician to include a prescription for ancillary materials. The label for ARCALYST requires the following ancillary materials:** 10-Sterile, 3-milliliter (mL) disposable syringes with markings at each 0.1 mL, 10-Sterile disposable needles (27 gauge 1/2 inches), 20-Alcohol wipes, 8-2x2 gauze pad, 4-Vial of preservative-free Sterile water for Injection, 1-Puncture-resistant container for disposal of used needles, syringes and vials.		
Prescriber's Signature:		Date:

Prescriber Declaration: I verify that the patient and prescriber information contained in this prescription form is complete and accurate to the best of my knowledge and that I have prescribed ARCALYST based on my professional judgment of medical necessity. I authorize the ARCALYST Resource Center (ARC) and the authorized agents of Regeneron Pharmaceuticals, Inc. to forward this prescription electronically, by facsimile, or by mail to the dispensing pharmacy.	
Prescriber's Full Signature:	Date:

Fax completed Prescription Form to: 1-888-876-2740

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