PRIOR AUTHORIZATION REQUEST
Arcalyst

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. What is the indication or diagnosis?
   - ☐ Cryopyrin-Associated Periodic Syndromes (CAPS) (including Familial Cold Autoinflammatory Syndrome [FCAS], Muckle-Wells Syndrome [MWS], and Neonatal Onset Multisystem Inflammatory Disease [NOMID] or chronic infantile neurological cutaneous and articular [CINCA] syndrome).
   - ☐ COVID-19 (Coronavirus Disease 2019) Note: This includes requests for cytokine release syndrome associated with COVID-19.
   - ☐ All other indications or diagnoses – Please specify _____
2. ☐ Yes ☐ No Is the patient currently receiving Arcalyst?
3. ☐ Yes ☐ No Has the patient had a response, as determined by the prescriber?
4. ☐ Yes ☐ No Is Arcalyst being prescribed by or in consultation with a rheumatologist, geneticist, allergist/immunologist, or dermatologist?
5. ☐ Yes ☐ No Will Arcalyst be used in combination with another biologic agent for an inflammatory condition?
6. Please provide the patient's diagnosis or indication, prescribed dose, frequency and route of administration, any other medications previously tried with duration of trial, and prescriber's or consultant's specialty. If the patient is already on this medication, when was it started?

_____
_____

Please document the diagnoses, symptoms, and/or any other information important to this review:

_____

_____

If you have any questions, call: 800-753-2851

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SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

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If you have any questions, call: 800-753-2851