Arcalyst (rilonacept)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
□ Familial Cold Auto-inflammatory Syndrome (FCAS) □ Muckle-Wells syndrome (MWS) □ Deficiency of interleukin-1 receptor antagonist(DIRA) □ Other Diagnosis_____ICD-10 Code(s):_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Will the drug be used in conjunction with a clinical trial? □ Yes □ No

Is prescriber a rheumatologist or immunologist? □ Yes □ No

Does patient have genetic evidence of an *NLRP3* mutation? □ Yes □ No Please submit documentation.

Does patient have signs and symptoms of FCAS such as recurrent, intermittent fever and rash that were exacerbated by exposure to generalized cool ambient temperature? □ Yes □ No Please submit documentation.

Does patient have signs and symptoms of MWS such as chronic fever and rash of waxing and waning intensity, sometimes exacerbated by exposure to generalized cool ambient temperature? □ Yes □ No Please submit documentation.

<u>For diagnosis of deficiency of interleukin-1 receptor antagonist(DIRA), answer the following:</u>
Does patient have lab confirmed homozygous mutations of *IL1RN* causing deficiency of interleukin-1 receptor antagonist? □ Yes □ No Please submit documentation.

Does patient exhibit clinical manifestations of DIRA such as diffuse pustular rash, sterile osteomyelitis, and/or periostitis with articular pain? □ Yes □ No Please submit documentation.

Does patient have any other rheumatic disease or major chronic infectious/inflammatory/immunologic disease such as inflammatory bowel disease, psoriatic arthritis, spondyloarthropathy, system lupus erythrematosus(SLE)? □ Yes □ No Please submit documentation.

Does patient require maintenance of remission of Deficiency of Interleukin-1 Receptor Antagonist (DIRA)? □ Yes □ No

Has patient had prior use with non-steroidal anti-inflammatories, methotrexate, and/or corticosteroids? □ Yes □ No Please submit documentation.

Has patient had prior use with at least 3 months of Kineret(anakinra)? □ Yes □ No Please submit documentation.

Revision Date: 9/1/2023

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ Date: _____

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program

Attn: CP – 4201

P.O. Box 64811

St. Paul, MN 55164-0811