



Arcalyst® (rilonacept)

PRIOR AUTHORIZATION REQUEST FORM

For authorization, **please answer each question, include patient chart notes to document clinical information, and fax this form back to the PEHP Prior Authorization Department at (801) 245-7774** or mail to: PEHP Pharmacy services, 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization questions, you may phone the PEHP Customer Service at (801) 366-7551.

1. Date:	2. Patient Name:	3. ID #:
4. D.O.B:	5. Physician:	6. Office Phone:
7. Office Fax:	8. Office Contact:	9. Dose Request:
10. Sex:	11. Weight:	

Authorization is requested from: _____ to _____
 Not to exceed 3 months for initial therapy. Additional therapy may be approved for up to 1 year.

Question	Yes	No	Comments/Notes
12. Is the patient 12 years of age or older?			
13. Does the patient have a history of auto immune disease or a recurrent or active serious infection?			
14. Has the patient received all recommended vaccinations?			
15. Is the diagnosis Cryopyrin-Associated Periodic Syndromes (CAPS)?			
16. If 'yes' to 15, please select the type of syndrome the patient has: <input type="checkbox"/> Familial Cold Autoinflammatory Syndrome (FCAS). <input type="checkbox"/> Muckle-Wells Syndrome (MWS). <input type="checkbox"/> Neonatal-Onset Multisystem Inflammatory Disease (NOMID). <input type="checkbox"/> Chronic Infantile Neurologic Cutaneous Articular Syndrome (CINCA). <input type="checkbox"/> Other* (please list indication): _____			Include clinical studies or articles to support the use of Arcalyst® if you listed a non-FDA approved indication.
17. Has the diagnosis been made through an analysis of family history, compilation of clinical history, including age of primary presentation and frequency/duration of episodes, physical examination, laboratory and histological testing or genetic analysis?			
18. Has the patient had previous Arcalyst® therapy?			
19. If 'yes' to 18, has the patient experienced an improvement of symptoms such as joint pain, rash, feeling fever/chills, eye redness/pain, or fatigue?			Documentation is required
20. Source of medication (select one): <input type="checkbox"/> Accredo <input type="checkbox"/> Approved Home Health			If no selection is made, Accredo must be used.
21. Indicate the facility Arcalyst® will be administered:			
22. Physician's Signature: _____			

PEHP USE ONLY	
Site of approval: Accredo or Approved Home Health	Home Health J-code: J2793

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