Arcalyst

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. What is the patient's diagnosis?
   ❑ Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Auto-inflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS)
   ❑ Deficiency of interleukin-1 receptor antagonist (DIRA)
   ❑ Recurrent pericarditis
   ❑ Other _____
2. What is the ICD-10 code? _____
3. *For a diagnosis of Cryopyrin-Associated Periodic Syndrome (CAPS):* The preferred product for your patient's health plan is Ilaris. Can the patient's treatment be switched to the preferred product? ***If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017 and no further questions.***
   ❑ Yes - Ilaris ❑ No - Continue request for Arcalyst
4. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #6*
5. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer Yes. ❑ Yes ❑ No *If No, skip to #7*
6. Does the patient have a documented inadequate response or intolerable adverse event to treatment with the preferred product, Ilaris? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No
7. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Otezla, Xeljanz)? ❑ Yes ❑ No
8. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis? *If Yes, skip to #12* ❑ Yes ❑ No
9. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [PPD], interferon-release assay [IGRA], chest x-ray) within 6 months of initiating therapy? ❑ Yes ❑ No

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10. What were the results of the tuberculosis (TB) test?
    ❑ Positive for TB ❑ Negative for TB, *skip to #12* ❑ Unknown

11. Which of the following applies to the patient?
    ❑ Patient has latent TB and treatment for latent TB has been initiated
    ❑ Patient has latent TB and treatment for latent TB has been completed
    ❑ Patient has latent TB and treatment for latent TB has not been initiated
    ❑ Patient has active TB

12. Is the requested drug being prescribed by or in consultation with any of the following?
    ❑ Cardiologist ❑ Rheumatologist ❑ Immunologist ❑ None of the above

13. Is this request for continuation of therapy with the requested drug?
    ❑ Yes ❑ No *If No, skip to diagnosis section.*

14. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to diagnosis section.* ❑ Yes ❑ No ❑ Unknown

15. Has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms since starting treatment with the requested drug?
    ❑ Yes ❑ No

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Cryopyrin-Associated Periodic Syndrome, Including Familial Cold Auto-inflammatory Syndrome and Muckle-Wells Syndrome

Initial therapy

16. Which is the patient's diagnosis?
    ❑ Familial cold auto-inflammatory syndrome (FCAS)
    ❑ Muckle-Wells syndrome (MWS), *skip to #18*
    ❑ None of the above

17. Does the patient have classic signs and symptoms of familial cold auto-inflammatory syndrome (FCAS) (i.e., recurrent, intermittent fever and rash that were often exacerbated by exposure to generalized cool ambient temperature)? *If Yes, skip to #19* ❑ Yes ❑ No

18. Does the patient have classic signs and symptoms of Muckle-Wells syndrome (MWS) (i.e., chronic fever and rash of waxing and waning intensity, sometimes exacerbated by exposure to generalized cool ambient temperature)? ❑ Yes ❑ No

19. Does the patient have functional impairment limiting the activities of daily living? ❑ Yes ❑ No

Section B: Deficiency of Interleukin-1 Receptor Antagonist

Initial therapy

20. Does the patient weigh 10 kg or more? ❑ Yes ❑ No

21. Does the patient have *IL1RN* mutations? ***ACTION REQUIRED: If Yes, attach documentation of IL1RN mutation status.*** ❑ Yes ❑ No

22. Will the requested drug be used for maintenance of remission following treatment with Kineret (anakinra)?
    ❑ Yes ❑ No

Section C: Recurrent Pericarditis

Continuation of therapy

26. Has the patient experienced a decreased recurrence of pericarditis? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting positive clinical response.*** ❑ Yes ❑ No

27. Has the patient experienced an improvement in signs and symptoms of the condition? ❑ Yes ❑ No

28. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response.***
Indicate ALL that apply and no further questions.
❑ Pericarditic chest pain ❑ Pericardial rubs ❑ Electrocardiogram (ECG)
❑ Pericardial effusion ❑ C-reactive protein (CRP) ❑ None of the above

Initial therapy

29. Has the patient had at least two episodes of pericarditis? ❑ Yes ❑ No

30. Has the patient failed at least two agents of standard therapy (e.g.,colchicine, non-steroidal anti-inflammatory drugs [NSAIDs], corticosteroids)? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.***
❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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