

## Immunomodulators: Arcalyst

### Member Information

1. Member Last Name: \_\_\_\_\_ 2. First Name: \_\_\_\_\_  
3. Member ID #: \_\_\_\_\_ 4. Member Date of Birth: \_\_\_\_\_ 5. Member Gender: \_\_\_\_\_

### Prescriber Information

6. Prescribing Provider NPI #: \_\_\_\_\_  
7. Requester Contact Information - Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Ext. \_\_\_\_\_

### Drug Information

8. Drug Name: \_\_\_\_\_ 9. Strength: \_\_\_\_\_ 10. Quantity Per 30 Days: \_\_\_\_\_  
11. Length of Therapy (in days):  up to 30 Days  60 Days  90 Days  120 Days  180 Days  365 Days   
Other \_\_\_\_\_

### Clinical Information

#### Request for Cryopyrin-Associated Periodic Syndromes (CAPS) including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS)

1. Does the member have a diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS) including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS)?  Yes  No
2. Is the member not on another injectable biologic immunomodulator?  Yes  No
3. Has the member been considered and screened for the presence of latent tuberculosis infection?  Yes  No
4. Has the member been tested with Hep B SAG and Core Ab?  Yes  No

#### Request for Deficiency of Interleukin-1 Receptor Antagonist (DIRA)

1. Does the member have a diagnosis of Deficiency of Interleukin-1 Receptor Antagonist (DIRA)?  Yes  No
2. Is the member not on another injectable biologic immunomodulator?  Yes  No
3. Has the member been considered and screened for the presence of latent tuberculosis infection?  Yes  No
4. Has the member been tested with Hep B SAG and Core Ab?  Yes  No
  - A) Is agent being used for maintenance of remission?  Yes  No
  - B) Does member weigh at least 10kg?  Yes  No

#### Request for Recurrent pericarditis (RP) and reduction in risk of recurrence

1. Does the member have a diagnosis of recurrent pericarditis?  Yes  No
2. Is the member at least 12 years of age?  Yes  No
3. Is the member not on another injectable biologic immunomodulator?  Yes  No
4. Has the member been considered and screened for the presence of latent tuberculosis infection?  Yes  No
5. Has the member been tested with Hep B SAG and Core Ab?  Yes  No

Signature of Prescriber: \_\_\_\_\_ Date: \_\_\_\_\_

**(Prescriber Signature Mandatory)**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.