

**ARCALYST (Non-Preferred)**  
**PRIOR AUTHORIZATION FORM**

Arcalyst is a Non-Preferred agent on the Medical Assistance Preferred Drug List (PDL). To review the prior authorization guidelines, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter-Cytokine & CAM Antagonists (accessible at: <http://www.dhs.state.pa.us/publications/bulletinsearch/index.htm>).

**PRIOR AUTHORIZATION REQUEST INFORMATION**

New       Renewal       Additional Information (PA#: \_\_\_\_\_)  
# pages in this request: \_\_\_\_\_ Office contact name: \_\_\_\_\_ & Phone:(\_\_\_\_\_) \_\_\_\_\_

**RECIPIENT INFORMATION**

Name: \_\_\_\_\_ Recipient ID#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Prescriber Name: \_\_\_\_\_ Specialty: \_\_\_\_\_  
NPI#: \_\_\_\_\_ OR MA Provider ID#: \_\_\_\_\_ State License#: \_\_\_\_\_  
Prescriber Address: \_\_\_\_\_ Suite #: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_ Phone:(\_\_\_\_\_) \_\_\_\_\_ Fax:(\_\_\_\_\_) \_\_\_\_\_  
Long-term care facility (if applicable) contact name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

**MEDICAL INFORMATION**

Dose: \_\_\_\_\_ Quantity: \_\_\_\_\_ Refills: \_\_\_\_\_  Currently receiving Arcalyst therapy  
Diagnosis: \_\_\_\_\_ Diagnosis Code: \_\_\_\_\_ (Required)  
**Specialty Pharmacy Drug Program: Which Specialty pharmacy will be used?**  Diplomat Specialty Pharmacy  
 Walgreens Specialty Pharmacy  
**Specialist Type:**  Rheumatologist  Other: \_\_\_\_\_

**Please check all that apply to the Recipient and submit documentation**

- Screened for Tuberculosis
- Screened for Hepatitis B (antibody and/or surface antigen)
- Up-to-date with immunizations (if less than 21 years old, in accordance with EPSDT guidelines)

**Other Indications:** *Submit clinical documentation of diagnosis, supporting medical literature, and therapies that have been tried*

**RENEWAL REQUEST:**

Please submit documentation of how Arcalyst has helped the Recipient's condition & level of functioning.

PLEASE **FAX** COMPLETED FORM & SUPPORTING CLINICAL INFORMATION TO DHS – PHARMACY DIVISION

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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