pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

ARCALYST (rilonacept) (non-preferred) PRIOR AUTHORIZATION FORM

Cytokine and CAM Antagonists and **Quantity Limits/Daily Dose Limits** prior authorization guidelines are accessible on the Department's Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	Total # of pages: ______	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/State/Zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Product requested: ☐Arcalyst 220 mg injection ☐Arcalyst ________________	Recipient weight: __________ lbs / kg	
Dose/directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:	Dx code (*required*):	

Initial request

1. Check all that apply to the recipient and *submit documentation for each*.
   - ☐vaccinated for hepatitis B
   - ☐screened for hepatitis B (surface antigen and core antibody)
   - ☐screened for tuberculosis
   - ☐up-to-date with all age-appropriate immunizations

2. Is the recipient being treated for one of the following diagnoses? *Check applicable diagnosis.* ☐familial cold autoinflammatory syndrome (FCAS) ☐Muckle-Wells syndrome (MWS)	☐Yes – *Submit documentation supporting diagnosis.* ☐No – *Submit medical literature supporting the use of Arcalyst for the recipient's diagnosis.*

Renewal request

1. Since starting Arcalyst, did the recipient experience a positive clinical response and/or improved level of functioning?	☐Yes ☐No *Submit documentation of clinical response.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**:

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