

## 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.