JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Arcalyst

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4.

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

Referring Provider Info: ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ Same as Referring Provider ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____kg

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office*

Drug Information:

Strength/Measure _____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
Directions(sig) _____ *Route of administration* _____
Dosing frequency _____

Send completed form to: Priority Partners Fax: 1-866-212-4756

 Arcalyst SGM 1800-A – 04/2023.

Criteria Questions:

1. What is the patient's diagnosis?
   - ❑ Cryopyrin-Associated Periodic Syndrome (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. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic disease-modifying anti-rheumatic drug (DMARD) (e.g., Olumiant, Otezla, Xeljanz)? ❑ Yes ❑ No
4. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic DMARD (e.g., Olumiant, Xeljanz) associated with an increased risk of TB? *If Yes, skip to #8* ❑ Yes ❑ No
5. 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
6. What were the results of the tuberculosis (TB) test?
   ❑ Positive for TB ❑ Negative for TB, *skip to #8* ❑ Unknown
7. 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

   If diagnosis is Recurrent Pericarditis, skip to Section C
8. Is this request for continuation of therapy with Arcalyst? ❑ Yes ❑ No *If No, skip to diagnosis section*
9. 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 q Unknown
10. 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 *No further questions*

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

11. Which of the following diagnoses does the patient have?
    ❑ Familial cold auto-inflammatory syndrome (FCAS) ❑ Muckle-Wells syndrome (MWS), *skip to #13*
    ❑ None of the above
12. 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 #14* ❑ Yes ❑ No
13. 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
14. Does the patient have functional impairment limiting the activities of daily living? ❑ Yes ❑ No

Section B: Deficiency of Interleukin-1 Receptor Antagonist

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.jhhc.com

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

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

Section C: Recurrent Pericarditis

17. Is this request for continuation of therapy with Arcalyst? ❑ Yes ❑ No *If No, skip to #23*

18. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #23* ❑ Yes ❑ No ❑ Unknown

19. Has the patient achieved or maintained positive clinical response since starting treatment with the requested drug?
❑ Yes ❑ No

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

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

22. Which of the following has the patient experienced an improvement in? ***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

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

24. Has the patient failed at least 2 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 Priority Partners.

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

Send completed form to: Priority Partners Fax: 1-866-212-4756