CVS caremark™ {{PANUMCODE}}

Arcalyst

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

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)? *If Yes, skip to #6* ❑ 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? *If Yes, skip to #8* ❑ Yes ❑ No
6. Does the patient have risk factors for tuberculosis (TB) (e.g., persons with close contact to people with infectious TB disease; persons who have recently immigrated from areas of the world with high rates of TB [e.g., Africa, Asia, Eastern Europe, Latin America, Russia]; children less than 5 years of age who have a positive TB test; groups with high rates of TB transmission [e.g., homeless persons, injection drug users, persons with HIV infection], or persons who work or reside with people who are at an increased risk for active TB [e.g., hospitals, long-term care facilities, correctional facilities, homeless shelters])? ❑ Yes ❑ No *If No, skip to #11.*
7. Has the patient been tested for tuberculosis (TB) within the previous 12 months? ❑ Yes ❑ No
8. What were the results of the tuberculosis (TB) test?
   ❑ Positive for TB
   ❑ Negative for TB, *skip to #11*
   ❑ Unknown
9. Does the patient have latent or active tuberculosis (TB)? ❑ Latent ❑ Active ❑ Unknown

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10. Has treatment for latent tuberculosis (TB) infection been initiated or completed?
    ❑ Yes - treatment initiated ❑ Yes - treatment completed ❑ No
    If diagnosis is Recurrent Pericarditis, skip to Section C

11. Is this request for continuation of therapy with Arcalyst? ❑ Yes ❑ No *If No, skip to diagnosis section*

12. 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 ❑ Unknown

13. 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

14. Which of the following diagnoses does the patient have?
    ❑ Familial cold auto-inflammatory syndrome (FCAS)
    ❑ Muckle-Wells syndrome (MWS), *skip to #16*
    ❑ No

15. 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 #17* ❑ Yes ❑ No

16. 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

17. Does the patient have functional impairment limiting the activities of daily living? ❑ Yes ❑ No

Section B: Deficiency of Interleukin-1 Receptor Antagonist

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

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

Section C: Recurrent Pericarditis

20. Is this request for continuation of therapy with Arcalyst? ❑ Yes ❑ No *If No, skip to #26*

21. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #26* ❑ Yes ❑ No ❑ Unknown

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

23. 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

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

25. 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

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

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27. Has the patient failed therapy with colchicine? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.*** ❑ Yes ❑ No

28. Has the patient failed therapy with non-steroidal anti-inflammatory drugs (NSAIDs)? ***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 CVS Caremark or the benefit plan sponsor.

X_____

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

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