Jefferson Health Plans

2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Arcalyst (Rilonacept) - Medicare

Phone: 215-991-4300 Fax back to: 866-371-3239

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Does the patient have a confirmed diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS), Familial Cold Autoinflammatory Syndrome (FCAS), Muckle-Wells Syndrome (MWS)?

☐ Yes ☐ No

Q2. Is the patient 12 years of age or older?

☐ Yes ☐ No

Q3. Does the patient have a confirmed diagnosis of Deficiency of Interleukin-1 Receptor Antagonist (DIRA)?

☐ Yes ☐ No

Q4. Does the patient weight at least 10kg?

☐ Yes ☐ No

Q5. Is documentation attached showing the need for maintenance of remission of DIRA?

☐ Yes ☐ No

Q6. Does the patient have a diagnosis of recurrent pericarditis (RP)?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q7. Is documentation attached showing a trial of, intolerance to, or contraindication to at least one of the following: nonsteroidal anti-inflammatory drugs, colchicine, or corticosteroids?

☐ Yes ☐ No

Q8. Requested Duration:

☐ 12 Months ☐ Other:

Q9. Additional Information:

_____ _____

Prescriber Signature Date