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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Arcalyst SGM 1800-A – 07/2023.

Criteria Questions:

What is the ICD-10 code? _____

1. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Otezla, Xeljanz)?
❒ Yes, *Continue to 2*
❒ No, *Continue to 2*

2. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis?
❒ Yes, *Continue to 6*
❒ No, *Continue to 3*

3. 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, *Continue to 4*
❒ No, *Continue to 4*

4. What were the results of the tuberculosis (TB) test?
❒ Positive for TB, *Continue to 5*
❒ Negative for TB, *Continue to 6*
❒ Unknown, *Continue to 6*

5. Which of the following applies to the patient?
❒ Patient has latent TB and treatment for latent TB has been initiated, *Continue to 6*
❒ Patient has latent TB and treatment for latent TB has been completed, *Continue to 6*
❒ Patient has latent TB and treatment for latent TB has not been initiated, *Continue to 6*
❒ Patient has active TB, *Continue to 6*

6. What is the patient's diagnosis?
❒ Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS), *Continue to 7*
❒ Deficiency of interleukin-1 receptor antagonist (DIRA), *Continue to 16*
❒ Recurrent pericarditis, *Continue to 23*
❒ Other, please specify., *No further questions*

7. Is the patient 12 years of age or older?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. Is the requested drug being prescribed by or in consultation with a rheumatologist or immunologist?
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

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9. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 10*
❒ No, *Continue to 12*

10. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 12*

❒ No, *Continue to 11*

❒ Unknown, *Continue to 12*

11. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms since starting treatment with the requested drug?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

12. Which is the patient's diagnosis?

❒ Familial cold autoinflammatory syndrome (FCAS), *Continue to 13*

❒ Muckle-Wells syndrome (MWS), *Continue to 14*

❒ None, *No further questions*

13. Does the patient have classic signs and symptoms of familial cold autoinflammatory syndrome (FCAS) (i.e., recurrent, intermittent fever and rash that were often exacerbated by exposure to generalized cool ambient temperature)?
❒ Yes, *Continue to 15*
❒ No, *Continue to 15*

14. 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, *Continue to 15*
❒ No, *Continue to 15*

15. Does the patient have functional impairment limiting the activities of daily living?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

16. Does the patient weigh 10 kg or more?
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. Is the requested drug being prescribed by or in consultation with a rheumatologist or immunologist?
❒ Yes, *Continue to 18*
❒ No, *Continue to 18*

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18. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 19*
❒ No, *Continue to 21*

19. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 21*

❒ No, *Continue to 20*

❒ Unknown, *Continue to 21*

20. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms since starting treatment with the requested drug?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

21. Does the patient have IL1RN mutations? ***ACTION REQUIRED***: If Yes, please attach documentation of IL1RN mutation status.
❒ Yes, *Continue to 22*
❒ No, *Continue to 22*

22. Will the requested drug be used for maintenance of remission following treatment with Kineret (anakinra)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

23. Is the patient 12 years of age or older?
❒ Yes, *Continue to 24*
❒ No, *Continue to 24*

24. Is the requested drug being prescribed by or in consultation with a cardiologist, rheumatologist, or immunologist?
❒ Yes, *Continue to 25*
❒ No, *Continue to 25*

25. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 26*
❒ No, *Continue to 31*

26. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 31*

❒ No, *Continue to 27*

❒ Unknown, *Continue to 31*

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27. Has the patient achieved or maintained a positive clinical response since starting treatment with the requested drug?
❒ Yes, *Continue to 28*
❒ No, *Continue to 28*

28. Has the patient experienced a decreased recurrence of pericarditis? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation supporting positive clinical response.
❒ Yes, *No Further Questions*
❒ No, *Continue to 29*

29. Has the patient experienced an improvement in signs and symptoms of the condition?
❒ Yes, *Continue to 30*
❒ No, *Continue to 30*

30. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED***: Please attach chart notes or medical record documentation supporting positive clinical response.

❒ Pericarditic chest pain ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ Pericardial rubs ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ Electrocardiogram (ECG) ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ Pericardial effusion ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ C-reactive protein (CRP) ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ None of the above, *No further questions*

31. Has the patient had at least two episodes of pericarditis?
❒ Yes, *Continue to 32*
❒ No, *Continue to 32*

32. Has the patient failed at least two 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. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

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)**

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