SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-800-750-9692.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization may be delayed.**

Drug Requested: Arcalyst® (rilonacept) **(Pharmacy) (Non-Preferred)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

Diagnosis	Recommended Dose
Cryopyrin -Associated Periodic Syndromes (CAPS), including Familial Cold Auto - inflammatory Syndrome (FCAS) and Muckle - Wells Syndrome (MWS) in adults and children ≥ 12 years old.	**SUBCUTANEOUS** **Adults 18 years and older:** • Loading dose: 320mg, delivered as two 160 mg (2 mL) injections. • Maintenance dose -160 mg (2 mL) injection once weekly. **Pediatrics 12 to 17 years:** • Loading dose: 4.4 mg/kg,up to a maximum of 320 mg, delivered as 1 or 2 injections (up to 2 mL/injection). Maintenance dose: 2.2 mg/kg, up to a maximum of160 mg (2 mL) injection once weekly.

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Diagnosis	Recommended Dose
Maintenance of remission of deficiency of interleukin -1 receptor antagonist (DIRA) in adults and pediatric patients weighing ≥ 10 kg	**SUBCUTANEOUS** • DIRA Adults and pediatric patients weighing at least 10 kg is 4.4mg/kg up to a maximum of 320mg delivered as 1 or 2 subcutaneous injections once weekly
Treatment of recurrent pericarditis and reduction risk in adults and pediatric patients children ≥ 12 years old.	**SUBCUTANEOUS** **Adults 18 years and older:** • Initial 320mg; maintenance 160mg once weekly **Pediatrics 12 years to 17 years**: • Loading dose: 4.4 mg/kg, up to a maximum of 320 mg, delivered as 1 or 2 injections (up to 2 mL/injection). Maintenance dose: 2.2 mg/kg, up to a maximum of 160 mg (2 mL) injection once weekly

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ **DIAGNOSIS: Cryopyrin -Associated Periodic Syndromes (CAPS), including Familial Cold Auto -inflammatory Syndrome (FCAS) and Muckle -Wells Syndrome(MWS).** Boxes must be checked to qualify.

❑ Member is 12 years of age or older

AND

❑ Member has a confirmed diagnosis of Cryopyrin -Associated Periodic Syndromes (CAPS), including:
- ❑ Familial Cold Auto -inflammatory Syndrome (FCAS); **OR**
- ❑ Muckle -Wells Syndrome (MWS)

❑ **DIAGNOSIS: Deficiency of interleukin -1 receptor antagonist (DIRA).** Boxes must be checked to qualify.

❑ Member must weigh > 10 kg

AND

❑ Member has a confirmed diagnosis of a genetic mutation in the deficiency of interleukin-1 receptor antagonist (DIRA)

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❑ **DIAGNOSIS: Pericarditis, recurrent.** Boxes must be checked to qualify.

- ❑ Member is 12 years of age or older

AND

- ❑ Member has a confirmed diagnosis of recurrent pericarditis defined as a history of at least three episodes of pericarditis in the past year

Medication being provided by a Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*