



Arcalyst

HMSA QUEST - 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 1-866-237-5512.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414**. 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: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Patient's Phone Number: _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

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

Additional Demographic Information:

Patient Weight: _____ *kg*
Patient Height: _____ *ft* _____ *inches*

Indicate where the drug is being dispensed:

- Office Outpatient Hospital Ambulatory Surgical Inpatient Hospital
- Off Campus Outpatient Hospital Urgent Care Emergency Room Birthing Center
- Military Facility Skilled Nursing Facility Nursing Facility Hospice
- Inpatient Psychiatric Psychiatric Residential Treatment End Stage Renal Facility
- Psychiatric Facility Pharmacy Other

Indicate where the drug is being administered:

- Ambulatory surgical Home Inpatient Hospital
- Office Outpatient Hospital Pharmacy

What is the ICD-10 code? _____

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512

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Criteria Questions:

General Biologic/Targeted Synthetic Drug and TB

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 #100*
 No, *Continue to #3*

3. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [TST], interferon-release assay [IGRA]) 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 #100*
 Unknown, *No Further Questions*

5. Which of the following applies to the patient?

- Patient has latent TB and treatment for latent TB has been initiated, *Continue to #100*
 Patient has latent TB and treatment for latent TB has been completed, *Continue to #100*
 Patient has latent TB and treatment for latent TB has not been initiated, *Continue to #100*
 Patient has active TB, *Continue to #100*

Diagnosis

100. What is the patient's diagnosis?

- Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Auto-inflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS), *Continue to #101*
 Deficiency of interleukin-1 receptor antagonist (DIRA), *Continue to #200*
 Recurrent pericarditis, *Continue to #300*
 Other, *No Further Questions*

Cryopyrin-Associated Periodic Syndromes (CAPS)

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

- Yes, *Continue to #102*
 No, *Continue to #102*

102. Is the requested drug prescribed by or in consultation with a rheumatologist or immunologist?

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- Yes, *Continue to #103*
- No, *Continue to #103*

103. Is this request for continuation of therapy with the requested drug?

- Yes, *Continue to #104*
- No, *Continue to #106*

Continuation of Therapy

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

- Yes, *Continue to #106*
- No, *Continue to #105*
- Unknown, *Continue to #106*

105. Has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug? **Action Required:** If yes, please attach documentation (e.g., chart notes or medical record) supporting a beneficial response to therapy

- Yes, *No Further Questions*
- No, *No Further Questions*

Initial Therapy

106. Which is the patient's diagnosis? **Action Required:** Please attach documentation supporting the diagnosis. If genetic testing is not available/no mutation identified, chart notes/medical record must be submitted

- Familial cold auto-inflammatory syndrome (FCAS), *Continue to #107*
- Muckle-Wells syndrome (MWS), *Continue to #108*
- None, *No Further Questions*

107. 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)?

- Yes, *Continue to #109*
- No, *Continue to #109*

108. 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 #109*
- No, *Continue to #109*

109. Does the patient have functional impairment limiting the activities of daily living?

- Yes, *No Further Questions*
- No, *No Further Questions*

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Deficiency of interleukin-1 receptor antagonist (DIRA)

200. Does the patient weigh 10 kg or more?

- Yes, Continue to #201
 No, Continue to #201

201. Is the requested drug being prescribed by or in consultation with a rheumatologist or immunologist?

- Yes, Continue to #202
 No, Continue to #202

202. Is this request for continuation of therapy with the requested drug?

- Yes, Continue to #203
 No, Continue to #205

Continuation of Therapy

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

- Yes, Continue to #205
 No, Continue to #204
 Unknown, Continue to #205

204. 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

Initial Therapy

205. Does the patient have IL1RN mutations? **ACTION REQUIRED:** If 'Yes', please attach documentation of IL1RN mutation status

- Yes, Continue to #206
 No, Continue to #206

206. Will the requested drug be used for maintenance of remission following treatment with Kineret (anakinra)?

- Yes, No Further Questions
 No, No Further Questions

Recurrent pericarditis

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

- Yes, Continue to #301
 No, Continue to #301

301. Is the requested drug being prescribed by or in consultation with a cardiologist, rheumatologist, or immunologist?

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- Yes, *Continue to #302*
 No, *Continue to #302*

302. Is this request for continuation of therapy with the requested drug?

- Yes, *Continue to #303*
 No, *Continue to #310*

Continuation of Therapy

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

- Yes, *Continue to #310*
 No, *Continue to #304*
 Unknown, *Continue to #310*

304. Has the patient achieved or maintained a positive clinical response as evidenced by decreased recurrence of pericarditis? ***ACTION REQUIRED:*** *Please attach chart notes or medical record documentation supporting positive clinical response*

- Yes, *No Further Questions*
 No, *Continue to #305*

305. Has the patient achieved or maintained a positive clinical response as evidenced by an improvement in signs and symptoms of the condition since starting treatment with the requested drug?

- Yes, *Continue to #306*
 No, *Continue to #306*

306. 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 or pleuritic chest pain, *No Further Questions*
 Pericardial or pleural rubs, *No Further Questions*
 Electrocardiogram (ECG), *No Further Questions*
 Pericardial effusion, *No Further Questions*
 C-reactive protein (CRP), *No Further Questions*
 None of the above, *No Further Questions*

Initial Therapy

310. Has the patient had at least two episodes of pericarditis?

- Yes, *Continue to #311*
 No, *Continue to #311*

311. 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*

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- 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 CVS Caremark or the benefit plan sponsor.

X

Prescriber or Authorized Signature

Date (mm/dd/yy)

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