Prior Authorization Form

Note: Please provide as much information as possible on this form. Missing data may cause processing delays for requested authorization(s). Attach additional sheets to this form if necessary.

Please fax the completed PA form and any additional informational sheets to Nirvanahealth at the following fax number: +1(866) 871-8565

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
Health Plan Name:		Prescriber Address:	
Patient Insurance Id:			
Patient Date of Birth:		Prescriber Phone:	( )
Patient Phone:		Prescriber Fax:	( )
		Prescriber Specialty:	
		Prescriber DEA:	
		Prescriber NPI:	

Medication & Medical Information	
Requested Drug(s) & Strength(s):	[ ] Arcalyst 220 mg subcutaneous solution
Requested Daily Quantity Limit – Amount:	
Requested Daily Quantity Limit – Days:	
Requested Quantity Limit Over Time – Amount:	
Requested Quantity Limit Over Time – Days:	
Requested Quantity Per Rx – Amount:	
Expected Length of Therapy:	
Directions:	
Diagnosis and Diagnosis Codes (ICD-10 Standard Codes):	
List drugs used previously to treat the same condition:	
Additional clinical information or history. Please include any relevant test results and/or medical record notes:	

Questionnaire

Q1: I, as the provider or designated representative of the provider, certify and attest that the information provided is complete and accurate and that, upon request, I shall provide any information to RxAdvance that RxAdvance determines is reasonably necessary to verify my responses. (Check only one that apply)

[ ] Yes

[ ] No

Q2: Is the member currently treated with this medication? (Check only one that apply)

[ ] Yes (please list start date of therapy (month/day/year)) _____

(*Required)

[ ] No

Q3: What is the member's diagnosis? (Check only one that apply)

[ ] Cryopyrin-Associated Periodic Syndromes (CAPS)

[ ] Recurrent Pericarditis

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request)
_____(*Required)

Q4: Has the member experienced disease stability or improvement in clinical symptoms while on therapy as evidence by one of the following: improvement in rash, fever, joint pain, headache, conjunctivitis, decreased number of disease flare days, normalization of inflammatory markers (CRP, ESR, SAA), corticosteroid dose reduction, OR improvement in MD global score or active joint count? (Check only one that apply)

[ ] Yes (please specify the type of positive clinical response) _____
(*Required)

[ ] No (please provide medical justification for continuation of therapy)
_____(*Required)

Q5: Does the member have a documentation of positive clinical response to therapy? (Check only one that apply)

[ ] Yes (please provide documentation supporting positive clinical response to therapy)
_____(*Required)

[ ] No (please provide medical justification for continuation of therapy)
_____(*Required)

Q6: What is the member's diagnosis? (Check only one that apply)

[ ] Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Auto-inflammatory Syndrome (FCAS) and/or Muckle-Wells Syndrome (MWS)

[ ] Recurrent Pericarditis

[ ] Deficiency of Interleukin-1 Receptor Antagonist (DIRA)

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request)
_____(*Required)

Q7: Will the request be used in combination with another biologic medication? (Check only one that apply)

[ ] Yes (please provide clinical rationale for the request) _____
(*Required)

[ ] No

Q8: Is the member's weight atleast 10 kg? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request) _____
(*Required)

Q9: Is the member currently in remission (e.g., no fever, skin rash, and bone pain/no radiological evidence of active bone lesions/C-reactive protein [CRP] less than 5 mg/L)? (Check only one that apply)

[ ] Yes (please specify the type of remission observed) _____
(*Required)

[ ] No (please provide medical justification for continuation of therapy)
_____(*Required)

Q10: Does the member have recurrent pericarditis as evidenced by at least 2 episodes that occur a minimum of 4 to 6 weeks apart? (Check only one that apply)

[ ] Yes (please specify the number of episodes) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____
(*Required)

Q11: Has the member had an inadequate response, intolerance or experienced contraindication(s) to at least one of the following: nonsteroidal anti-inflammatory drugs (e.g., ibuprofen, naproxen), colchicine, or corticosteroids (e.g., prednisone)? (Check only one that apply)

[ ] Yes (please specify at least one drug name, corresponding contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____
(*Required)

Q12: Is the medication prescribed by or in consultation with a cardiologist? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request) _____
(*Required)

Q13: Does the medication prescribed by or in consultation with an immunologist, allergist, dermatologist, rheumatologist, neurologist, or specialist with expertise in the management of CAPS? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request) _____
(*Required)

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, Insurer, Medical Group or its designated representatives may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Signature of Prescriber or Authorized Representative:	Date:
Print Authorized Representative Name:	