South Dakota Department of Social Services

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
Mon-Sat: 7am to 7pm Central

Arcalyst® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Cryopyrin-associated periodic syndromes (CAPS) [including familial cold autoinflammatory syndrome (FCAS) and Muckle-Wells syndrome (MWS)]
- ❑ Deficiency of interleukin-1 receptor antagonist (DIRA)
- ❑ Recurrent pericarditis
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Select if the requested medication is diagnosed by, or upon consultation with or recommendation of the following specialists:
❑ Allergist/Immunologist ❑ Dermatologist ❑ Neurologist ❑ Rheumatologist ❑ Other _____

Will the requested medication be used in combination with another biologic agent? ❑ **Yes** ❑ **No**

For recurrent pericarditis, answer the following:

Has the patient had an inadequate response or intolerance to, or contraindication to a trial of colchcine or one oral systemic glucocorticoids? ❑ **Yes** ❑ **No** List _____

Quantity limit requests:

What is the quantity requested per TREATMENT? _____ syringe every _____ weeks

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

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Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.