Prescriber Criteria Form

Arcalyst 2025 PA Fax 597-A v2 010125.docx
Arcalyst (rilonacept)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Arcalyst (rilonacept).

Drug Name:
Arcalyst (rilonacept)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS) including one of the following: A) Familial Cold Auto-Inflammatory Syndrome (FCAS), B) Muckle-Wells Syndrome (MWS)? [If yes, then no further questions.]	Yes ◯	No ◯
2	Is the requested drug being prescribed for the prevention of gout flares? [If no, then skip to question 10.]	Yes ◯	No ◯
3	Is the patient initiating or continuing urate-lowering therapy (e.g., allopurinol)? [If no, then no further questions.]	Yes ◯	No ◯
4	Is the patient currently taking the requested drug for prevention of gout flares? [If no, then skip to question 7.]	Yes ◯	No ◯
5	Has the patient achieved or maintained a clinical benefit (i.e., a fewer number of gout attacks or fewer flare days) compared to baseline? [If no, then no further questions.]	Yes ◯	No ◯
6	Has the patient continued use of urate-lowering therapy concurrently with the requested drug? [No further questions.]	Yes ◯	No ◯

7	Has the patient had two or more gout flares within the previous 12 months? [If no, then no further questions.]	Yes ◯	No ◯
8	Has the patient had an inadequate response, intolerance or contraindication to maximum tolerated doses of a non-steroidal anti-inflammatory drug (NSAID) and colchicine? [If no, then no further questions.]	Yes ◯	No ◯
9	Will the patient use the requested drug concurrently with urate-lowering therapy? [No further questions.]	Yes ◯	No ◯
10	Does the patient have a diagnosis of deficiency of interleukin-1 receptor antagonist (DIRA)? [If no, then skip to question 12.]	Yes ◯	No ◯
11	Will the requested drug be used for maintenance of remission? [No further questions.]	Yes ◯	No ◯
12	Will the requested drug be used for the treatment of recurrent pericarditis (RP) and reduction in risk of recurrence? [If no, then no further questions.]	Yes ◯	No ◯
13	Has the patient had an inadequate response, intolerance, or contraindication to maximum tolerated doses of a non-steroidal anti-inflammatory drug (NSAID) and colchicine?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____