



Send completed form to:
 Peach State Health Plan Pharmacy Department
 Fax: 1-866-374-1579

Arcalyst, Ilaris
Prior Authorization Request

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 toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copy or medication delivery; please contact Peach State Health Plan at 1-800-514-0083 option # 2.

Patient Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Physician Office Address: _____

1. Which drug is being prescribed? Arcalyst Dose: _____ Frequency: _____
 Ilaris Dose: _____ Frequency: _____
 2. What is the diagnosis? CAPS including Familial Cold Auto-inflammatory Syndrome (FCAS)
 CAPS including Muckle-Wells syndrome (MWS)
 CAPS including Neonatal-onset multisystem inflammatory disease (NOMID)/Chronic infantile neurologic cutaneous and articular (CINCA)
 Other _____
 3. Does the patient have an active infection? Yes No
 4. Prior to initiating therapy, did the patient have negative tuberculosis (TB) test? **If yes, skip to #6*
 Yes No
 5. Has the patient been treated for latent TB infection? Yes No
 6. Prior to therapy, is the patient up to date on immunizations including pneumococcal and influenza vaccines? Yes No
 7. Is the patient currently receiving the prescribed medication? Yes No **If yes, skip to #11*
 8. How old is the patient? _____ years
 9. Which of the following therapies has the patient **tried and failed**? Arcalyst Ilaris Kineret
 10. To which of the following therapies is the patient **contraindicated**? Arcalyst Ilaris Kineret
- Only answer question below if patient is currently receiving Arcalyst or Ilaris therapy**
11. Has the patient demonstrated therapeutic response? Yes No

Information given on this form is accurate as of this date:

X _____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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