

Immunomodulators Temporary PA Request Form**Cryopyrin-Associated Periodic Syndromes including Familial Cold
Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS)
(Arcalyst and Ilaris)****Beneficiary Information**

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Recipient Gender: _____

Prescriber Information

6. Prescribing Provider NPI#: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext: _____

Drug Information

8. Med requested: _____ 9a. Strength _____ 9b. Quantity per 30 days _____ 9c. Length of therapy _____

10. Does the beneficiary have a diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS) including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS)?
YES ___ **NO** ___

11. Is the beneficiary on any other injectable immunomodulator? **YES** ___ **NO** ___

12. Has the beneficiary been screened for latent tuberculosis infection? **YES** ___ **NO** ___

13. Has the beneficiary been tested with Hep B SAG and Core Ab? **YES** ___ **NO** ___
Date of lab and result _____

Signature of Prescriber: _____ Date: _____

(Prescriber signature mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: (877) 386-4695

Pharmacy PA Call Center: (833) 585-4309