AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Deficiency of Interleukin-1 Receptor Antagonist (DIRA) (Arcalyst and Kineret)

Beneficiary Information

1. Beneficiary Last Name: ________________________________ 2. First Name: ________________________________
3. Beneficiary ID #: ____________________ 4. Beneficiary Date of Birth: ______________ 5. Beneficiary Gender: _________

Prescriber Information

7. Prescriber Name: ____ NPI #: _________________________
Mailing address: _______________________________________ City: _____________ State: _________ ZIP: _______
8. Requester Contact Information: ____
Name: _______________________________ Phone #: _______________________ Fax #: ________________________

Drug Information

8. Drug Name: ______________ 9. Strength: _______________ 10. Quantity Per 30 Days: _____________
11. Length of Therapy: __up to 30 days __60 days __90 days __120 days __180 days __365 days __Other: ______

Clinical Information

1. Does the beneficiary have a diagnosis of a Deficiency of Interleukin-1 Receptor Antagonist (DIRA)? Yes___ No___
2. Is the beneficiary on any other injectable immunomodulator? Yes___ No___
3. Has the beneficiary been screened for latent tuberculosis infection? Yes___ No___
4. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes___ No___

For Arcalyst Only:

5. Is the medication being used for maintenance of remission of a Deficiency of Interleukin-1 Receptor Antagonist (DIRA)? Yes___ No___
6. Does the beneficiary weigh at least 10kg? Yes___ No___

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: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406