Cigna®

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Arcalyst
(rilonacept)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
Arcalyst 220mg powder for injection: ☐ Dose: Duration of therapy:

Frequency of therapy: ICD10:

Is this a new start or continuation of therapy? ☐ new start ☐ continuation of therapy
(if continued therapy) is your patient having a positive clinical response to Arcalyst? ☐ Yes ☐ No

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Is your patient a candidate for home infusion? Yes ☐ No ☐
Does the physician have an in-office infusion site? Yes ☐ No ☐

Diagnosis related to use:
☐ Chronic Infantile Neurological Cutaneous and Articular (CINCA) Syndrome
☐ Deficiency of interleukin-1 receptor antagonist (DIRA)
☐ Familial Cold Autoinflammatory Syndrome (FCAS)
☐ Muckle-Wells Syndrome (MWS)
☐ Neonatal-Onset Multisystem Inflammatory Disease (NOMID)
☐ Pericarditis
☐ Other *(please specify)*:

Clinical Information:
(if CINCA, FCAS, MWS, NOMID)Is the requested drug prescribed by or in consultation with a rheumatologist, geneticist, allergist/immunologist, or dermatologist? ☐ Yes ☐ No
(if DIRA) Does your patient weigh 10 kg (22 lbs) or more? ☐ Yes ☐ No

if DIRA) Has the patient undergone genetic testing that confirmed a mutation in the IL1RN gene? ☐ Yes ☐ No

(if DIRA) Has the patient demonstrated a clinical benefit with Kineret (examples include normalized acute phase reactants; resolution of fever, skin, rash, and bone pain; and reduced dosage of corticosteroids)? ☐ Yes ☐ No

(if DIRA) Is the requested drug prescribed by, or in consultation with, a rheumatologist, geneticist, dermatologist, or a physician specializing in the treatment of autoinflammatory disorders? ☐ Yes ☐ No

(if pericarditis) Does your patient have recurrent disease?
☐ Yes ☐ No ☐ Unknown

(if pericarditis) Prior to starting treatment with Arcalyst, did/does the individual have a history of at least three episodes of pericarditis in the past year? ☐ Yes ☐ No

(if pericarditis) For the current episode, does the patient have acute signs and symptoms of pericarditis despite standard treatment? Notes: Standard treatments include nonsteroidal anti-inflammatory drug(s) [NSAIDs], colchicine, and/or systemic corticosteroids.
☐ Yes ☐ No

(if no) Is standard treatment (nonsteroidal anti-inflammatory drug(s) [NSAIDs], colchicine, and/or systemic corticosteroids) contraindicated in this patient? ☐ Yes ☐ No

(if pericarditis) Is the medication prescribed by or in consultation with a cardiologist or rheumatologist? ☐ Yes ☐ No
Is/Will the requested drug be used at the same time as any other biologic therapy for an inflammatory condition? ☐ Yes ☐ No

Additional Pertinent Information: *(including disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently):*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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