

PREAUTHORIZATION FORM
Arcalyst™ and Ilaris®
(rilonacept and canakinumab)

Therapeutic use: Interleukin-1 blockers indicated to treat two rare cryopyrin-associated periodic syndromes (CAPS), Familial Cold Auto-inflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS)

Quantity Limit: N/A

Authorization Period: 6 months

Patient's name _____

Patient's ID# [][][][][][][][][] DOB [][] / [][] / [][][][][]

ICD-9 [][][][][][][][][][] _____

Physician's name _____

Physician's Ph# ([][][][]) [][][][][] - [][][][][] Fax# [][][][][] - [][][][][]

Physician's signature _____ Date signed [][] / [][] / [][][][][]

Supervising Physician's name _____ (Required if requesting provider is a nurse practitioner or physician assistant)

Please check "Yes" or "No" and respond to the following requests:			
1.	Has the patient been diagnosed with Familial Cold Autoinflammatory Syndrome (FCAS)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	Has the patient been diagnosed with Muckle-Wells Syndrome (MWS)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Important Note: Arcalyst or Ilaris should not be used in the presence of an active or chronic infection. Combination use with a TNF-inhibitor is not recommended.			

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.