TEXAS MEDICAID
Clinical Edit Prior Authorization
rilonacept (ARCALYST)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

STEP 2: MEDICATION INFORMATION	
Medication Requested (Name):	Quantity Requested:
Dose Requested:	Dosing Instructions:

Patient's Primary Diagnosis: _____ ICD 10 Code: _____

Please indicate ONE (1) of the following:

☐ STAR / STAR KIDS client **(Go to Step 3 - PDL PA Criteria Applies)**

OR ☐ CHIP / PERINATE client **(Go to Step 4)**

STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT

1. Has the client failed a 30-day treatment trial with at least one (1) preferred agent in the last 180 days?

   ☐ Yes (Go to Step 4, Question 1) ☐ No (Go to #2)

2. Is there a documented allergy or contraindication to preferred agents in this class?

   ☐ Yes (Go to Step 4, Question 1) ☐ No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

   ☐ Yes (Go to Step 4, Question 1) ☐ No (Deny)

STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Does the client have a diagnosis of deficiency of interleukin-1 receptor antagonist (DIRA) in the last 730 days?

   ☐ Yes (Go to #4) ☐ No (Go to #2)

2. Is the client greater than or equal to (≥) 12 years of age?

   ☐ Yes (Go to #3) ☐ No (Deny)

3. Does the client have a diagnosis of cryopyrin associated periodic syndrome (CAPS), familial cold auto-inflammatory syndrome (FCAS), Muckle-Wells syndrome (MWS), or recurrent pericarditis (RP) in the last 730 days?

   ☐ Yes (Go to #4) ☐ No (Deny)

4. Does the client have a claim for a biologic disease modifying anti-rheumatic drug (DMARD) in the last 30 days?

   Examples of biologic DMARDs include: ACTEMRA, CIMZIA, COSENTYX, ENBREL, HUMIRA, ILARIS, KEVZARA, KINERET, ORENCIA, OTEZLA, SILIQ, SIMPONI, STELARA, TALTZ, and TREMFYA

   ☐ Yes (Deny) ☐ No (Go to #5)

5. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

   ☐ Yes (Deny) ☐ No (Approve – 365 days)

STEP 5: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.

For questions, please call Navitus Customer Care at 1-877-908-6023.