

**Complete Patient and Physician information (PLEASE PRINT)**

STEP 1	Member Name:	Physician Name:
	Address:	Address:
	Member ID:	Phone #:
	Member DOB:	Fax #:
		Tax ID or NPI Number:

**If Applicable:** Pharmacy Name: \_\_\_\_\_  
Pharmacy Phone: \_\_\_\_\_

**Complete the Clinical Assessment:**

**Please attach all relevant medical records and test results**

STEP 2	Diagnosis	<input type="checkbox"/> Cryopyrin Associated Periodic Syndromes <input type="checkbox"/> Familial Cold Auto-inflammatory Syndrome (FCAS) <input type="checkbox"/> Muckle Wells Syndrome (MWS) <input type="checkbox"/> Neonatal Onset Multisystem Inflammatory Disease (NOMID)  <i>PA's for Arcalyst are only granted for FDA approved indications, including FCAS &amp; MWS. NOMID is not an FDA approved indication.</i>	<input type="checkbox"/> Other (please list):
	Clinical Considerations	Please attach clinical documentation of the following: <input type="checkbox"/> Chart notes citing symptomatology consistent with the indicated diagnosis <input type="checkbox"/> Genetic mutation of CIAS1/NLRP-3 gene <input type="checkbox"/> Patient must be ≥ 12 years of age	
	Physician Specialty	_____	
	Supporting Documentation Included <input type="checkbox"/>	Diagnosis: ICD-9 Code #/ Description / J Code (required):  Please attach a copy of the prescription or provide ALL of the information below: Arcalyst (rilonacept) Strength _____ Sig _____ Qty _____ Refills _____	
<b>Incomplete forms will not be processed.</b>			

**I certify that the above is correct and accurate to the best of my knowledge (please sign and date).**

STEP 3	_____	_____
	Prescriber Signature	Date

**STEP 4 Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk:  
970-248-5034**

Name of Person filling out form: \_\_\_\_\_

Pharmacy Technician initials \_\_\_\_\_ Date Initiated \_\_\_\_\_

**Confidentiality Notice:**

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