STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES TELEPHONE:
TELEPHONE: 1-866-409-8386 FAX: 1-866-759-4110

Cytokine and CAM – CAPS Agents
Clinical Prior Authorization (PA) Request Form
CT Medical Assistance Program
To Be Completed By Prescriber

Prescriber Information	Patient Information
Prescriber's NPI:	Patient's Medicaid ID Number:
Prescriber Name:	Patient Name:
Prescriber Subspecialty:	Patient Date of Birth:
Phone ( )	Patient Current Weight:
Fax ( )	Patient Primary ICD Diagnosis Code:
Prescription Information	
Drug, Strength, and Dosage Form Requested:	Frequency of Dosing:
□ New therapy □ Continuation	Quantity Requested:

Preferred Agents:	Non-Preferred Agents:
PREFERRED TNFi AGENTS (listed for reference): ADALIMUMAB-ADAZ PEN, SYRINGE ENBREL DISP SYRINGE, KIT, PEN ENBREL MINI CARTRIDGE, VIAL HADLIMA PUSHTOUCH, SYRINGE HUMIRA KIT, PEN INJECTION KIT INFLIXIMAB VIAL PREFERRED IL-6 AGENTS (listed for reference): TYENNE AUTOINJECT, SYRINGE TYENNE VIAL	ARCALYST VIAL ILARIS VIAL KINERET SYRINGE

Clinical Information

(attach supporting documentation, **required**)

Note: Using samples to initiate therapy does not meet authorization requirements

1. Prescribed by or in consultation with a rheumatologist, hematologist or any other specialist familiar with the treated disease state (or as appropriate for diagnosis)? o Please specify subspecialty:_____	□ Yes □ No

2. Is patient using in combination with another targeted immunomodulator? o Please specify alternate agent:_____	□ Yes □ No

For Initial Approval:
Medication Requested and Documented diagnosis of ONE of the following:

(attach supporting documentation, **required**)

Arcalyst (rilonacept): • Patient has a documented diagnosis of ONE of the following: o Cryopyrin-associated periodic syndrome (CAPS) (12+ years of age), including: ▪ Familial Cold Autoinflammatory Syndrome (FCAS) ▪ Muckle-Wells Syndrome (MWS) **OR** o Recurrent Pericarditis (RP) (12+ years of age) which is defined as a second instance of pericarditis after having no symptoms for at least 4 weeks **OR** o Deficiency of Interleukin-1 receptor antagonist (DIRA) in patients weighing at least 10kg, which has been confirmed by genetic testing biallelic pathogenic variants in IL 1 RN gene AND utilization is for the maintenance of remission of DIRA following previous treatment with Kineret (documentation required of trial)	□ Yes □ No
Ilaris (canakinumab): • Patient has a documented diagnosis of ONE of the following: o Period Fever Syndromes, including: ▪ Familial Mediterranean Fever (FMF) (2+ years of age) ▪ Tumor Necrosis Factor (TNF) Receptor Associated Periodic Syndrome (TRAPS) (2+ years of age) ▪ Hyperimmunoglobulin D (Hyper-IgD) Syndrome (HIDS/MKD) (2+ years of age) ▪ Cryopyrin-associated periodic syndrome (CAPS) (4+ years of age), including: • Familial Cold Autoinflammatory Syndrome (FCAS) • Muckle-Wells Syndrome (MWS) **OR** o Still's Disease, including: ▪ Adult-Onset Still's Disease (AOSD) (18+ years of age) **OR** ▪ Systemic Juvenile Idiopathic Arthritis (SJIA) (2+ years of age) **AND**	□ Yes □ No

• Adequate trial of tocilizumab or documented adverse event/adverse reaction or contraindication to tocilizumab (30 days minimum) o Explanation of Contraindication or Failure to Tocilizumab: _____ o Gout Flares (18+ years of age) for whom non-steroidal anti-inflammatory drugs (NSAIDs) and colchicine are contraindicated, are not tolerated, or do not provide an adequate response, and in whom repeated courses of corticosteroids are not appropriate ▪ Explanation of Contraindication or Failure to NSAID/Colchicine: _____	
Kineret (anakinra): • Patient has a documented diagnosis of ONE of the following: o Deficiency of Interleukin-1 Receptor Antagonist (DIRA) which has been confirmed by genetic testing biallelic pathogenic variants in IL 1 RN gene **OR** o Neonatal-onset multisystem inflammatory disease (NOMID) **OR** o Rheumatoid Arthritis (RA) (18+ years of age) **AND** ▪ Patient has had an adequate trial (30 days minimum) of DMARD therapy, including a TNF inhibitor • Preferred agent trialed: _____ • Trial Dates: _____ • Reason for Failure: _____	□ Yes □ No

Renewal Information

(attach supporting documentation, **required**)

Note: Using samples to initiate therapy does not meet renewal authorization requirements

• Has the patient previously met the required criteria set forth in Initial Approval Section above? o Previous Approved Prior Authorization Number: _____ o Approval Dates: _____	□ Yes □ No
• Patients' clinical response to treatment and ongoing safety has been documented and monitored	□ Yes □ No

• Prescriber attests that the patient has a continued need for therapy and is compliant with current regimen	□ Yes □ No

Please Note: Pharmacies should not be contacting prescribers to provide pre-signed PA forms or submitting pre-signed forms for PA, nor should prescribing providers be requesting that pharmacies perform PA activities for them. PA requests must originate from the prescriber, and only the prescriber should sign the form at the time of PA submission.
I certify that documentation is maintained in my files and the information given is true and accurate for the medication requested, subject to penalty under section 17b-99 of the Connecticut General Statutes and sections 17-83k-1- to 17-83k-7, inclusive, of the Regulations of Connecticut State Agencies. I certify that the above-referenced member is a patient under my clinic's/practice's ongoing care. I understand that a prior authorization may not exceed one (1) year from the date of fill for non- controlled medications. Authorizations for Early Refill Requests are valid one time only.

Prescriber Signature*:_____ Date:_____

*** Mandatory (others may not sign for prescriber). In accordance with federal law, prescribers must be enrolled in the Connecticut Medical Assistance Program (CMAP). CMAP will not pay for prescriptions written by a non-enrolled provider.**