UnitedHealthcare Community Plan

NC Pharmacy Prior Approval Request for

Immunomodulators: Deficiency of Interleukin-1 Receptor Antagonist (DIRA)

(Arcalyst and Kineret)

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: ____

Prescriber Information

6. Prescribing Provider NPI #: _____ Provider Fax #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days:_____
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

☐ Other _____

Clinical Information

1. Does the beneficiary have a diagnosis of a Deficiency of Interleukin-1 Receptor Antagonist (DIRA)? ☐ Yes ☐ No
2. Is the beneficiary on any other injectable immunomodulator? ☐ **Yes** ☐ **No**
3. Has the beneficiary been screened for latent tuberculosis infection? ☐ **Yes** ☐ **No**
4. Has the beneficiary been tested with Hep B SAG and Core Ab? ☐ **Yes** ☐ **No**
5. Is the medication being used for maintenance of remission of a Deficiency of Interleukin-1 Receptor Antagonist (DIRA) ? ☐ **Yes** ☐ **No** **(For Arcalyst only)**
6. Does the beneficiary weigh at least 10kg? ☐ **Yes** ☐ **No** **(For Arcalyst only)**

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to 1-866-940-7328 Pharmacy PA Call Center: 1-855-258-1593