PRIOR AUTHORIZATION REQUEST
Ilaris

PATIENT: Name______________________
Address: ______________________
City, State, Zip_____________________
D.O.B. _____________________
Member ID:________________________

Prescriber: Name______________________
Address ______________________
City, State, Zip_____________________
Phone _____________________
Fax _____________________
NPI _____________________

Medication Requested:____________ Qty Requested: ____________

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. ☐ Yes ☐ No Will Ilaris be used in combination with another biologic agent for an inflammatory condition?
2. ☐ Yes ☐ No Is the patient currently receiving Ilaris?
3. What is the indication or diagnosis?
   - ☐ Cryopyrin-associated periodic Syndromes (CAPS) (including familial cold autoinflammatory syndrome [FCAS], Muckle-Wells syndrome [MWS], and neonatal onset multisystem inflammatory disease [NOMID] or chronic infantile neurological cutaneous and articular [CINCA] syndrome) – **Please answer questions 4 & 7**
   - ☐ Familial Mediterranean fever (FMF) **- Please answer questions 5 & 15**
   - ☐ Hyperimmunoglobulin D syndrome (HIDS)/mevalonate kinase deficiency (MKD) - **Please answer questions 5 & 14**
   - ☐ Systemic juvenile idiopathic arthritis (SJIA) - **Please answer questions 6 & 8 – 13**
   - ☐ Tumor necrosis factor receptor associated periodic syndrome (TRAPS) - **Please answer questions 5 & 14**
   - ☐ Stills disease, adult onset (Please Note: If the patient is less than 18 years of age, select systemic juvenile idiopathic arthritis.) - **Please answer questions 9, 10, 12, 13 & 16 – 18**
   - ☐ Rheumatoid arthritis
   - ☐ COVID-19 (Coronavirus Disease 2019) Note: This includes requests for cytokine release syndrome Associated with COVID-19. - **Please answer question 19**
   - ☐ All other indications or diagnoses (Please specify): ____________________________________
4. ☐ Yes ☐ No Has the patient had a response, as determined by the prescriber?
5. ☐ Yes ☐ No Has the patient had a response, as determined by the prescriber? Note: The patient may not have a full response, but there should have been a recent or past response to Ilaris.
6. ☐ Yes ☐ No Has the patient had a response, as determined by the prescriber?

If you have any questions, call: 800-753-2851

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7. ☐ Yes ☐ No Is Ilaris being prescribed by or in consultation with a rheumatologist, geneticist, allergist/immunologist, or dermatologist?
8. ☐ Yes ☐ No Has the patient tried at least TWO other biologics for SJIA?
9. ☐ Yes ☐ No Does the patient have features of poor prognosis, as determined by the prescriber?
10. ☐ Yes ☐ No Has the patient tried Actemra or Kineret?
11. ☐ Yes ☐ No Does the patient have features of SJIA with active systemic features with concerns of progression to macrophage activation syndrome (MAS), as determined by the prescriber?
12. ☐ Yes ☐ No Has the patient tried Kineret?
13. ☐ Yes ☐ No Is Ilaris being prescribed by or in consultation with a rheumatologist?
14. ☐ Yes ☐ No Is Ilaris being prescribed by or in consultation with a rheumatologist, nephrologist, geneticist, oncologist, or hematologist?
15. ☐ Yes ☐ No Is Ilaris being prescribed by or in consultation with a rheumatologist, nephrologist, geneticist, gastroenterologist, oncologist, or hematologist?
16. ☐ Yes ☐ No Has the patient tried at least TWO other biologics?
17. ☐ Yes ☐ No Does the patient have active systemic features with concerns of progression to macrophage activation syndrome, as determined by the prescriber?
18. ☐ Yes ☐ No Has the patient had a response as determined by the prescriber?
19. Please provide the patient's diagnosis or indication, prescribed dose, frequency and route of administration, any other medications previously tried with duration of trial, and prescriber's or consultant's specialty. If the patient is already on this medication, when was it started?

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Please document the diagnoses, symptoms, and/or any other information important to this review:

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SECTION B Physician Signature

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PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior

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Confidentiality: The information contained in this transmission is confidential and may be protected under

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