PRIOR AUTHORIZATION REQUEST

ILARIS

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Will the requested medication be used in combination with another biologic agent for an inflammatory condition? [Note: Examples include Cimzia, Enbrel, Erelzi, Humira, Amjevita, Simponi SC, Simponi Aria, Remicade, Inflectra, Renflexis, Actemra (SC or IV), Kevzara, Orencia (SC or IV), Rituxan, Kineret, Stelara (SC or IV), Siliq, Cosentyx, Taltz, Tremfya, Arcalyst.] [If yes, no further questions.]	Yes	No
2	Is the request an INITIAL or CONTINUATION of therapy?		

If you have any questions, call: 1-888-258-8250

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[] Initial (If checked, go to 8)

[] Continuation (If checked, go to 3)

3	Is the patient currently receiving the requested medication? [If no, skip to question 8.]	Yes	No
4	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 8.]	Yes	No
5	Does the patient have a previously approved PA on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 8.]	Yes	No
6	Has the patient been established on therapy for AT LEAST 3 months? [If no, skip to question 8.]	Yes	No
7	Has documentation been provided to confirm that the patient has had a clinically significant response? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No

8 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) (If checked, go to 9)

[] Familial Mediterranean fever (FMF) (If checked, go to 16)

[] Hyperimmunoglobulin D syndrome (HIDS)/mevalonate kinase deficiency (MKD) (If checked, go to 23)

[] Still's disease, adult onset (AOSD) [Note: If the patient is less than 18 years of age, select systemic juvenile idiopathic arthritis.] (If checked, go to 27)

[] Systemic juvenile idiopathic arthritis (SJIA) (If checked, go to 31)

[] Tumor necrosis factor receptor associated periodic syndrome (TRAPS) (If checked, go to 39)

[] Rheumatoid arthritis (RA) (If checked, no further questions)

[] Coronavirus Disease 2019 (COVID-19) [Note: This includes requests for cytokine release syndrome associated with COVID-19.] (If checked, no further questions)

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	[] Other (If checked, no further questions)		
9	Is the patient greater than or equal to 4 years of age? [If no, no further questions.]	Yes	No
10	Is there laboratory evidence of a genetic mutation (such as in the Cold-Induced Autoinflammatory Syndrome 1 [*CIAS1* also referred to as the NLRP-3])? [If no, no further questions.]	Yes	No
11	Does the patient have elevated inflammatory markers (C-reactive protein [CRP] and serum amyloid A)? [If no, no further questions.]	Yes	No
12	Does the patient have AT LEAST TWO of SIX typical Cryopyrin-associated periodic Syndromes (CAPS) manifestations: A) Urticaria-like rash, B) Cold-triggered episodes, C) Sensorineural hearing loss, D) Musculoskeletal symptoms, E) Chronic aseptic meningitis, F) Skeletal abnormalities? [If no, no further questions.]	Yes	No
13	Does the patient have functional impairment limiting the activities of daily living? [If no, no further questions.]	Yes	No
14	Is the requested medication being prescribed by or in consultation with a rheumatologist, nephrologist, geneticist, gastroenterologist, oncologist, or hematologist? [If no, no further questions.]	Yes	No
15	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the indication? (Note: Weight greater than 40 kg: 150 mg subq every 8 weeks, weight 15 kg to less than 40 kg: 2 mg/kg subq every 8 weeks.) [No further questions.]	Yes	No
16	Is the patient greater than or equal to 2 years of age? [If no, no further questions.]	Yes	No
17	Does the patient have a failure, contraindication, or intolerance to colchicine? [If yes, skip to question 19.]	Yes	No
18	Will the patient be using the requested medication in combination with colchicine? [If no, no further questions.]	Yes	No
19	Prior to starting the requested medication, is the patient's C-reactive protein (CRP) level greater than or equal to 10 mg/L OR elevated to AT LEAST TWO times the upper limit of normal for the reporting laboratory? [If no, no further questions.]	Yes	No
20	Prior to starting the requested medication, does the patient have a history of AT	Yes	No

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	LEAST ONE flare per month despite use of colchicine OR was hospitalized for a severe flare? [If no, no further questions.]		
21	Is the requested medication being prescribed by or in consultation with a rheumatologist, nephrologist, geneticist, gastroenterologist, oncologist, or hematologist? [If no, no further questions.]	Yes	No
22	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the indication? (Note: Weight greater than 40 kg: 150 mg subq every 4 weeks, weight 15 kg to less than 40 kg: 2 mg/kg subq every 4 weeks.) [No further questions.]	Yes	No
23	Is the patient greater than or equal to 2 years of age? [If no, no further questions.]	Yes	No
24	Prior to starting the requested medication, is the patient's C-reactive protein (CRP) level greater than or equal to 10 mg/L OR elevated to AT LEAST TWO times the upper limit of normal for the reporting laboratory? [If no, no further questions.]	Yes	No
25	Prior to starting the requested medication, does the patient have a history of AT LEAST THREE febrile acute flares within the previous 6-month period OR was hospitalized for a severe flare? [If no, no further questions.]	Yes	No
26	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the indication? (Note: Weight greater than 40 kg: 150 mg subq every 4 weeks, weight 15 kg to less than 40 kg: 2 mg/kg subq every 4 weeks.) [No further questions.]	Yes	No
27	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
28	Is the request medication being prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
29	Has the patient had a trial and failure, contraindication or intolerance to ALL of the following: A) Corticosteroids for AT LEAST 3 months, B) Conventional synthetic disease modifying antirheumatic drug (DMARD) for AT LEAST 3 months, C) Nonsteroidal anti-inflammatory drugs (NSAIDs) for AT LEAST 3 months? [If no, no further questions.]	Yes	No
30	Does the requested dose exceed Food and Drug Administration (FDA) approved	Yes	No

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	label dosing for the indication? (Note: Weight greater than 7.5 kg is 4 mg/kg [max 300 mg] subq every 4 weeks.) [No further questions.]		
31	Is the patient greater than or equal to 2 years of age? [If no, no further questions.]	Yes	No
32	Is the requested medication being prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
33	Has the patient tried AT LEAST TWO systemic agents for this condition for AT LEAST 3 months? [Note: Examples of one other systemic agent tried include a corticosteroid (oral, IV), a conventional synthetic disease modifying antirheumatic drug [DMARD] (for example, methotrexate [MTX], leflunomide, sulfasalazine).] [If yes, skip to question 35.]	Yes	No
34	Has documentation been provided to confirm that the patient has an intolerance to AT LEAST TWO agents? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of one other systemic agent tried include a corticosteroid (oral, IV), a conventional synthetic disease modifying antirheumatic drug [DMARD] (for example, methotrexate [MTX], leflunomide, sulfasalazine).] [If no, no further questions.]	Yes	No
35	Has documentation been provided to confirm that the patient has an intolerance, contraindication to, or failed treatment for AT LEAST 3 months with preferred Tumor necrosis factor (TNF) inhibitors, Enbrel (etanercept) and an adalimumab product (Hadlima, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
36	Has documentation been provided to confirm that the patient has an intolerance, contraindication to, or failed treatment for AT LEAST 3 months with preferred Janus kinase (JAK) inhibitor, Xeljanz? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
37	Is the requested medication being prescribed by or in consultation with a rheumatologist, nephrologist, geneticist, gastroenterologist, oncologist, or hematologist? [If no, no further questions.]	Yes	No
38	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the indication? (Note: Weight greater than 7.5 kg is 4 mg/kg [max 300 mg] subq every 4 weeks.) [No further questions.]	Yes	No

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39	Is the patient greater than or equal to 2 years of age? [If no, no further questions.]	Yes	No
40	Prior to starting the requested medication, is the patient's C-reactive protein (CRP) level greater than or equal to 10 mg/L OR elevated to AT LEAST TWO times the upper limit of normal for the reporting laboratory? [If no, no further questions.]	Yes	No
41	Prior to starting the requested medication, does the patient have a history of AT LEAST SIX flares per year period OR was hospitalized for a severe flare? [If no, no further questions.]	Yes	No
42	Will the requested medication be used in combination with biologics or disease modifying antirheumatic drugs (DMARDs)? [If yes, no further questions.]	Yes	No
43	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the indication? (Note: Weight greater than 40 kg: 150 mg subq every 4 weeks, weight 15 kg to less than 40 kg: 2 mg/kg subq every 4 weeks.)	Yes	No

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

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

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 authorization as per Plan policy and procedures.

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If you have any questions, call: 1-888-258-8250