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	Is the request for an INITIAL or a CONTINUATION of therapy? [] Initial (If checked, go to 6) [] Continuation (If checked, go to 2)		
2	Is the patient currently receiving the requested medication? [If no, skip to question 6.]	Yes	No
3	Has the patient been receiving medication samples for the requested medication?	Yes	No

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	[If yes, skip to question 6.]		
4	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 6.]	Yes	No
5	Has the patient been taking the requested medication for AT LEAST 3 months and has experienced a clinically significant benefit from the medication, as documented by the prescriber? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
6	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 7) [] Familial Mediterranean fever (FMF) (If checked, go to 14) [] Hyperimmunoglobulin D syndrome (HIDS)/mevalonate kinase deficiency (MKD) (If checked, go to 20) [] 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 24) [] Systemic juvenile idiopathic arthritis (SJIA) (If checked, go to 28) [] Tumor necrosis factor receptor associated periodic syndrome (TRAPS) (If checked, go to 35) [] Gout Flare (If checked, go to 40) [] Other (If checked, no further questions)		
7	Is the patient greater than or equal to 4 years of age? [If no, no further questions.]	Yes	No
8	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
9	Does the patient have elevated inflammatory markers (C-reactive protein [CRP] and serum amyloid A)? [If no, no further questions.]	Yes	No

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10	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
11	Does the patient have functional impairment limiting the activities of daily living? [If no, no further questions.]	Yes	No
12	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
13	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the indication? [Dosing: 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
14	Is the patient greater than or equal to 2 years of age? [If no, no further questions.]	Yes	No
15	Has documentation been submitted that patient has tried Colchicine for AT LEAST 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
16	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
17	Prior to starting the requested medication, does the patient have a history of AT LEAST ONE flare per month despite use of colchicine OR was hospitalized for a severe flare? [If no, no further questions.]	Yes	No
18	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
19	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the indication? [Dosing: 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

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20	Is the patient greater than or equal to 2 years of age? [If no, no further questions.]	Yes	No
21	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? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
22	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
23	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the indication? [Dosing: 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
24	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
25	Is the request medication being prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
26	Has documentation been submitted that the patient has 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? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
27	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the indication? [Dosing: Weight greater than 7.5 kg is 4 mg/kg (max 300 mg) subq every 4 weeks.] [No further questions.]	Yes	No
28	Is the patient greater than or equal to 2 years of age? [If no, no further questions.]	Yes	No
29	Is the requested medication being prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No

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30	Has documentation been submitted to confirm that the patient has had a treatment failure with AT LEAST 2 systemic agents for AT LEAST 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [Note: Examples 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
31	Has documentation been submitted to confirm that the patient has had a treatment failure with an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-adbm) for AT LEAST 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
32	Has documentation been submitted to confirm that the patient has had a treatment failure with Xeljanz (tofacitinib) for AT LEAST 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
33	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
34	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the indication? [Dosing: Weight greater than 7.5 kg is 4 mg/kg (max 300 mg) subq every 4 weeks.] [No further questions.]	Yes	No
35	Is the patient greater than or equal to 2 years of age? [If no, no further questions.]	Yes	No
36	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
37	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
38	Will the requested medication be used in combination with biologics or disease modifying antirheumatic drugs (DMARDs)? [If yes, no further questions.]	Yes	No
39	Does the requested dose exceed Food and Drug Administration (FDA) approved	Yes	No

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	label dosing for the indication? [Dosing: 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.]		
40	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
41	Has documentation been submitted to show that the patient has AT LEAST 3 flares in the last 12 months prior to starting the requested medication? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
42	Has documentation been submitted to confirm that the patient has had treatment failure with AT LEAST 1 formulary nonsteroidal anti-inflammatory drug (NSAID) for AT LEAST 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
43	Has documentation been submitted to confirm that the patient has had treatment failure with Colchicine for AT LEAST 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
44	Has documentation been submitted to confirm that the patient has had treatment failure with Corticosteroids for AT LEAST 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
45	Has documentation been submitted to confirm that the patient has had treatment failure with interleukin-1 beta blocker, Kineret, for AT LEAST 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
46	Is the requested medication being prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
47	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the indication? [Dosing: 150 mg subq every 12 weeks.]	Yes	No

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

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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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