Ilaris

Prior Authorization Request

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Inpatient Hospital* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Criteria Questions:

1. What is the patient's diagnosis?
   - ❑ Systemic juvenile idiopathic arthritis (sJIA)
   - ❑ Cryopyrin-Associated Periodic Syndrome (CAPS), including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS)
   - ❑ Gout
   - ❑ Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS)
   - ❑ Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD)
   - ❑ Familial Mediterranean Fever (FMF)
   - ❑ Polyarticular juvenile idiopathic arthritis (pJIA)

❑ Other _____

2. What is the ICD-10 code? _____

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Systemic Juvenile Idiopathic Arthritis (sJIA)

3. Has the patient been diagnosed active with active systemic juvenile idiopathic arthritis (sJIA)?
   ❑ Yes ❑ No
4. Is this request for continuation of therapy with Ilaris? ❑ Yes ❑ No
5. Is the patient currently receiving Ilaris through samples or a manufacturer's patient assistance program?
   If Yes or Unknown, skip to #8 ❑ Yes ❑ No ❑ Unknown
6. How long has the patient been receiving the requested medication? _____ months
7. Has the patient achieved or maintained positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms? ❑ Yes ❑ No
8. Has the patient previously received therapy with Kineret or Actemra? ❑ Yes ❑ No
9. Has the patient received or experienced an inadequate response to treatment with corticosteroids (e.g., prednisone, methylprednisone), methotrexate, or leflunomide? ❑ Yes ❑ No

Section B: Gout

10. Is Ilaris being prescribed to treat acute gout attacks? ❑ Yes ❑ No
11. Is the patient currently receiving Ilaris? *If Yes, skip to #15* ❑ Yes ❑ No
12. How many gout flares has the patient had within the previous 12 months? _____
13. Has the patient had an inadequate response or intolerance at previous attacks, or contraindication to at least two of the following? ***Indicate all that apply or mark "None of the above."***
    ❑ Maximum tolerated doses of NSAIDs
    ❑ Colchicine
    ❑ Intra-articular injection of triamcinolone acetonide at doses 40 mg or greater
    ❑ Systemic corticosteroids
    ❑ None of the above
14. Will the patient receive Ilaris concurrently with urate-lowering therapy (i.e., allopurinol or febuxostat)?
    ❑ Yes ❑ No
15. Has the patient experienced a positive clinical response from treatment with Ilaris (e.g., reduction in swelling within 72 hours, reduction in pain compared to prior attacks, or delayed time to flare compared to prior attacks)?
    ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**