# Ilaris

## Prior Authorization Request

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 **1-888-877-0518.** 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.

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**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?
   ❑ Cryopyrin-Associated Periodic Syndrome (CAPS), including Familial Cold Auto-inflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS)
   ❑ Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS)
   ❑ Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD)
   ❑ Familial Mediterranean Fever (FMF)
   ❑ Systemic Juvenile idiopathic arthritis (sJIA)
   ❑ Polyarticular juvenile idiopathic arthritis (pJIA)
   ❑ Gout flares
   ❑ Pseudogout (also known as calcium pyrophosphate deposition disease) flares
   ❑ Adult-onset Still's disease
   ❑ Other _____

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

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2. What is the ICD-10 code? _____

3. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic disease-modifying anti-rheumatic drug (DMARD) (e.g., Olumiant, Otezla, Xeljanz)? ❑ Yes ❑ No

4. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic DMARD (e.g., Olumiant, Xeljanz)? *If Yes, skip to #6* ❑ Yes ❑ No

5. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [PPD], interferon-release assay [IGRA], chest x-ray) within 6 months of initiating therapy? *If Yes, skip to #8* ❑ Yes ❑ No

6. Does the patient have risk factors for tuberculosis (TB) (e.g., persons with close contact to people with infectious TB disease; persons who have recently immigrated from areas of the world with high rates of TB [e.g., Africa, Asia, Eastern Europe, Latin America, Russia]; children less than 5 years of age who have a positive TB test; groups with high rates of TB transmission [e.g., homeless persons, injection drug users, persons with HIV infection], or persons who work or reside with people who are at an increased risk for active TB [e.g., hospitals, long-term care facilities, correctional facilities, homeless shelters])? ❑ Yes ❑ No *If No, skip to #11*

7. Has the patient been tested for tuberculosis (TB) within the previous 12 months? ❑ Yes ❑ No

8. What were the results of the the tuberculosis (TB) test?
❑ Positive for TB ❑ Negative for TB ❑ Unknown *If Negative, skip to #11*

9. Does the patient have latent or active tuberculosis (TB)? ❑ Latent ❑ Active ❑ Unknown

10. Has treatment for latent tuberculosis (TB) infection been initiated or completed?
❑ Yes – treatment initiated ❑ Yes – treatment completed ❑ No

11. Is this request for continuation of therapy with Ilaris? ❑ Yes ❑ No *If No, skip to diagnosis section.*

12. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to diagnosis section* ❑ Yes ❑ No ❑ Unknown

13. Has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms since starting treatment with the requested drug?
❑ Yes ❑ No

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

<u>Section A: Cryopyrin-Associated Periodic Syndromes</u>

14. Does the patient have functional impairment limiting the activities of daily living? ❑ Yes ❑ No

15. Which of the following diagnoses does the patient have?
❑ Familial cold auto-inflammatory syndrome (FCAS)
❑ Muckle-Wells syndrome (MWS)*, skip to #17*
❑ None

16. Does the patient have classic signs and symptoms of familial cold auto-inflammatory syndrome (FCAS) (i.e., recurrent, intermittent fever and rash that were often exacerbated by exposure to generalized cool ambient temperature)? ❑ Yes ❑ No *No further questions*

17. Does the patient have classic signs and symptoms of Muckle-Wells syndrome (MWS) (i.e., chronic fever and rash of waxing and waning intensity, sometimes exacerbated by exposure to generalized cool ambient temperature)?
❑ Yes ❑ No

<u>Section B: Tumor Necrosis Factor Receptor Associated Periodic Syndrome, Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD)</u>

18. *If diagnosis is tumor necrosis factor receptor associated periodic syndrome,* does the patient have chronic or recurrent disease activity? ❑ Yes ❑ No

19. Has the patient had active flares within the last 6 months? ❑ Yes ❑ No


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20. What is the patient's Physician's Global Assessment score? _____ ❑ Unknown
*If two or more, no further questions.*

21. What is the patient's C-reactive protein (CRP) level in mg/L? _____ mg/L ❑ Unknown

Section C: Familial Mediterranean Fever

22. Does the patient have active disease with flares within the last 6 months? ❑ Yes ❑ No

23. What is the patient's C-reactive protein (CRP) level in mg/L? _____ mg/L ❑ Unknown

24. Has the patient had an inadequate response or intolerance to colchicine?
*If Yes, no further questions* ❑ Yes ❑ No

25. Does the patient have a contraindication to colchicine? ❑ Yes ❑ No

Section D: Systemic Juvenile Idiopathic Arthritis

26. Has the patient been diagnosed with active systemic juvenile idiopathic arthritis (sJIA)? ❑ Yes ❑ No

27. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for active systemic juvenile idiopathic arthritis? *If Yes, no further questions* ❑ Yes ❑ No

28. Has the patient experienced an inadequate response to any of the following medications after treatment for the specified duration?
❑ Yes - At least a 1-month trial of nonsteroidal anti-inflammatory drugs (NSAIDs)
❑ Yes - At least a 2-week trial of corticosteroids (e.g. prednisone, methylprednisolone)
❑ Yes - At least a 3-month trial of methotrexate or leflunomide
❑ No

Section E: Gout/Pseudogout Flares

29. Is Ilaris being requested for the management of flares for gout or pseudogout (also known as calcium pyrophosphate deposition disease)? ❑ Yes ❑ No

30. Has the patient had an inadequate response or intolerance to maximum tolerated doses of non-steroidal anti-inflammatory drugs (NSAIDs) or has a contraindication to NSAIDs? ❑ Yes ❑ No

31. Has the patient had an inadequate response or intolerance to maximum tolerated doses of colchicine or has a contraindication to colchicine? ❑ Yes ❑ No

32. Has the patient had an inadequate response or intolerance to maximum tolerated doses of oral and injectable corticosteroid? *If Yes, no further questions* ❑ Yes ❑ No

33. Does the patient have a clinical reason to avoid repeated courses of corticosteroids? ❑ Yes ❑ No

Section F: Adult-onset Still's disease

34. Has the patient been diagnosed with active adult-onset Still's disease (AOSD)? ❑ Yes ❑ No

35. Has the patient ever received (including current utilizers) a biologic indicated for active adult-onset Still's disease?
*If Yes, no further questions* ❑ Yes ❑ No

36. Has the patient experienced an inadequate response to any of the following medications after treatment for the specified duration?
❑ Yes - At least a 1-month trial of nonsteroidal anti-inflammatory drugs (NSAIDs)
❑ Yes - At least a 1-month trial of corticosteroids (e.g. prednisone, methylprednisolone))
❑ Yes - At least a 3-month trial of a conventional DMARD (e.g., methotrexate)
❑ 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)**

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**CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062**
**Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com**