



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 copy 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 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.

Section A: Cryopyrin-Associated Periodic Syndromes

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

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

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 (AOSD)

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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