Ilaris

HMSACOM - 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 1-866-237-5512**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414.** 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.

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

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

Additional Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*ft* _____*inches*

Indicate where the drug is being dispensed:

❑ Office ❑ Outpatient Hospital ❑ Ambulatory Surgical ❑ Inpatient Hospital
❑ Off Campus Outpatient Hospital ❑ Urgent Care ❑ Emergency Room ❑ Birthing Center
❑ Military Facility ❑ Skilled Nursing Facility ❑ Nursing Facility ❑ Hospice
❑ Inpatient Psychiatric ❑ Psychiatric Residential Treatment ❑ End Stage Renal Facility
❑ Psychiatric Facility ❑ Pharmacy ❑ Other

Indicate where the drug is being administered:

❑ Ambulatory surgical ❑ Home ❑ Inpatient Hospital
❑ Office ❑ Outpatient Hospital ❑ Pharmacy

What is the ICD-10 code? _____

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512

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), *Continue to #100*
❒ Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS), *Continue to #200*
❒ Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD), *Continue to #300*
❒ Familial Mediterranean Fever (FMF), *Continue to #400*
❒ Systemic Juvenile idiopathic arthritis (sJIA), *Continue to #500*
❒ Polyarticular juvenile idiopathic arthritis (pJIA), *No Further Questions*
❒ Gout flares, *Continue to #600*
❒ Adult-onset Still's disease (AOSD), *Continue to #700*
❒ Other, *No Further Questions*

Cryopyrin-Associated Periodic Syndromes

100. Is the patient 4 years of age or older?
❒ Yes, *Continue to #101*
❒ No, *No Further Questions*

101. Is the requested drug being prescribed by or in consultation with a rheumatologist or immunologist?
❒ Yes, *Continue to #102*
❒ No, *Continue to #102*

Continuation of Therapy

102. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to #103*
❒ No, *Continue to #105*

103. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to #105*
❒ No, *Continue to #104*
❒ Unknown, *Continue to #105*

104. 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? ***ACTION REQUIRED****: Please attach chart notes or medical record documentation supporting positive clinical response*
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Initial

105. Which of the following diagnoses does the patient have? ***ACTION REQUIRED:*** *Please attach results of genetic testing demonstrating a mutation in the NLRP3 gene and/or the NLRP12 gene OR chart notes/medical documentation confirming the diagnosis, in the absence of genetic testing*
❒ Familial cold auto-inflammatory syndrome (FCAS), *Continue to #106*
❒ Muckle-Wells syndrome (MWS), *Continue to #107*
❒ None, *No Further Questions*

106. 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, *Continue to #108*
❒ No, *Continue to #108*

107. 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, *Continue to #108*
❒ No, *Continue to #108*

108. Does the patient have functional impairment limiting the activities of daily living?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Tumor Necrosis Factor Receptor Associated Periodic Syndrome

200. Is the requested drug being prescribed by or in consultation with a rheumatologist or immunologist?
❒ Yes, *Continue to #201*
❒ No, *Continue to #201*

Continuation of Therapy

201. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to #202*
❒ No, *Continue to #204*

202. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to #204*
❒ No, *Continue to #203*
❒ Unknown, *Continue to #204*

203. 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? ***ACTION REQUIRED****: Please attach chart notes or medical record documentation supporting positive clinical response*
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Initial

204. Does the patient have chronic or recurrent disease activity?
❒ Yes, *Continue to #205*
❒ No, *Continue to #205*

205. Has the patient had active flares within the last 6 months?
❒ Yes, *Continue to #206*
❒ No, *Continue to #206*

206. What is the patient's Physician's Global Assessment score?

❒ Less than 2, *Continue to #207*
❒ 2 or greater, *No Further Questions*
❒ Unknown, *Continue to #207*

207. What is the patient's C-reactive protein (CRP) level in mg/L?
❒ 10 mg/L or less, *No Further Questions*
❒ Greater than 10 mg/L, *No Further Questions*
❒ Unknown, *No Further Questions*

Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD)

300. Is the requested drug being prescribed by or in consultation with a rheumatologist or immunologist?
❒ Yes, *Continue to #301*
❒ No, *Continue to #301*

Continuation of Therapy

301. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to #302*
❒ No, *Continue to #304*

302. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to #304*
❒ No, *Continue to #303*
❒ Unknown, *Continue to #304*

303. 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? ***ACTION REQUIRED****: Please attach chart notes or medical record documentation supporting positive clinical response*
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Initial

304. Has the patient had active flares within the last 6 months?
❒ Yes, *Continue to #305*
❒ No, *Continue to #305*

305. What is the patient's Physician's Global Assessment score?
❒ Less than 2, *Continue to #306*
❒ 2 or greater, *No Further Questions*
❒ Unknown, *Continue to #306*

306. What is the patient's C-reactive protein (CRP) level in mg/L?
❒ 10 mg/L or less, *No Further Questions*
❒ Greater than 10 mg/L, *No Further Questions*
❒ Unknown, *No Further Questions*

Familial Mediterranean Fever (FMF)

400. Is the requested drug being prescribed by or in consultation with a rheumatologist or immunologist?
❒ Yes, *Continue to #401*
❒ No, *Continue to #401*

Continuation of Therapy

401. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to #402*
❒ No, *Continue to #404*

402. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to #404*
❒ No, *Continue to #403*
❒ Unknown, *Continue to #404*

403. 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? ***ACTION REQUIRED****: Please attach chart notes or medical record documentation supporting positive clinical response*
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Initial

404. Does the patient have active disease with flares within the last 6 months?
❒ Yes, *Continue to #405*
❒ No, *Continue to #405*

405. What is the patient's C-reactive protein (CRP) level in mg/L?
❒ 10 mg/L or less, *Continue to #406*
❒ Greater than 10 mg/L, *Continue to #406*
❒ Unknown, *Continue to #406*

406. Has the patient had an inadequate response or intolerance to colchicine?
❒ Yes, *No Further Questions*
❒ No, *Continue to #407*

407. Does the patient have a contraindication to colchicine?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Systemic Juvenile Idiopathic Arthritis

500. Is the patient 2 years of age or older?
❒ Yes, *Continue to #501*
❒ No, *No Further Questions*

501. Is the requested drug being prescribed by or in consultation with a rheumatologist?
❒ Yes, *Continue to #502*

❒ No, *Continue to #502*

Continuation of Therapy

502. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to #503*
❒ No, *Continue to #506*

503. Is the patient currently receiving Ilaris through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to #506*
❒ No, *Continue to #504*
❒ Unknown, *Continue to #506*

504. 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, *Continue to #505*
❒ No, *Continue to #505*

505. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED****: Please attach chart notes or medical record documentation supporting positive clinical response*
❒ Number of joints with active arthritis (e.g., swelling, pain, limitation of motion), *No Further Questions*
❒ Number of joints with limitation of movement, *No Further Questions*
❒ Functional ability, *No Further Questions*
❒ Systemic features (e.g., fevers, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly, or serositis), *No Further Questions*
❒ None of the above, *No Further Questions*

Initial

506. Has the patient been diagnosed with active systemic juvenile idiopathic arthritis (sJIA)?
❒ Yes, *Continue to #507*
❒ No, *Continue to #507*

Prior treatment with another biologic drug

507. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for active systemic juvenile idiopathic arthritis? ***ACTION REQUIRED****: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried*
❒ Yes, *No Further Questions*
❒ No, *Continue to #508*

New starts

508. Does the patient have active systemic features (e.g., fever, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly, or serositis)?
❒ Yes, *Continue to #509*
❒ No, *Continue to #509*

509. Has the patient had an inadequate response to non-steroidal antiinflammatory drugs (NSAIDs) or systemic glucocorticoids? ***ACTION REQUIRED****: If Yes, please also attach chart notes, medical record documentation, or*

claims history supporting previous medications tried, including response to therapy
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Gout

600. Is Ilaris being requested for the management of flares for gout?
❒ Yes, *Continue to #601*
❒ No, *Continue to #601*

601. Is the requested drug being prescribed by or in consultation with a rheumatologist?
❒ Yes, *Continue to #602*
❒ No, *Continue to #602*

Continuation of Therapy

602. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to #603*
❒ No, *Continue to #605*

603. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to #605*
❒ No, *Continue to #604*
❒ Unknown, *Continue to #605*

604. 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 Further Questions*
❒ No, *No Further Questions*

Initial

605. 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, *Continue to #606*
❒ No, *Continue to #606*

606. Has the patient had an inadequate response or intolerance to maximum tolerated doses of colchicine or has a contraindication to colchicine?
❒ Yes, *Continue to #607*
❒ No, *Continue to #607*

607. Has the patient had an inadequate response or intolerance to maximum tolerated doses of oral and injectable corticosteroid?
❒ Yes, *No Further Questions*
❒ No, *Continue to #608*

608. Does the patient have a clinical reason to avoid repeated courses of corticosteroids?
❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

700. Is the requested drug being prescribed by or in consultation with a rheumatologist?
❒ Yes, *Continue to #701*
❒ No, *Continue to #701*

701. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to #702*
❒ No, *Continue to #705*

702. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to #705*
❒ No, *Continue to #703*
❒ Unknown, *Continue to #705*

703. Has the patient achieved or maintained positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms since starting treatment with the requested drug?
❒ Yes, *Continue to #704*
❒ No, *Continue to #704*

704. Which of the following has the patient experienced an improvement in from baseline
❒ Number of joints with active arthritis (e.g., swelling, pain, limitation of motion), *No Further Questions*
❒ Number of joints with limitation of movement, *No Further Questions*
❒ Functional ability, *No Further Questions*
❒ Systemic features (e.g., fevers, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly, or serositis), *No Further Questions*
❒ None of the above, *No Further Questions*

705. Has the patient been diagnosed with active adult-onset Still's disease (AOSD)?
❒ Yes, *Continue to #706*
❒ No, *Continue to #706*

706. Has the patient ever received (including current utilizers) a biologic indicated for active adult-onset Still's disease?
❒ Yes, *No Further Questions*
❒ No, *Continue to #707*

707. Does the patient have active systemic features (e.g., fever, arthralgia/arthritis, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly, sore throat)?
❒ Yes, *Continue to #708*
❒ No, *Continue to #708*

708. Has the patient experienced an inadequate response to a trial of nonsteroidal anti-inflammatory drugs (NSAIDs), corticosteroids, or a conventional synthetic drug (e.g., methotrexate)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

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)**

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512