Ilaris (for Maryland only)
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.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
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*

Criteria Questions:

1. What is the patient's diagnosis?
   - ❑ Cryopyrin-Associated Periodic Syndrome (CAPS), including Familial Cold Autoinflammatory 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)
   - ❑ Polyarticular juvenile idiopathic arthritis (pJIA)
   - ❑ Systemic juvenile idiopathic arthritis (sJIA)
   - ❑ Gout
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Would the prescriber like to request an override of the step therapy requirement?
   ❑ Yes ❑ No *If No, skip to diagnosis section*
4. Has the member received the medication through a pharmacy or medical benefit within the past 180 days?
   ❑ Yes ❑ No ***Action Required*: If Yes, please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e. PBM medication history, pharmacy receipt, EOB etc.)**
5. Is the medication effective in treating the member's condition?
   ❑ Yes ❑ No *Continue to the diagnosis section and complete this form in its entirety.*

Complete the following section based on the patient's diagnosis.

Section A: Systemic Juvenile Idiopathic Arthritis (sJIA)

6. Has the patient been diagnosed active with active systemic juvenile idiopathic arthritis (sJIA)?
   ❑ Yes ❑ No *If No, skip to #10*

7. Has the patient received at least a 28-day supply of Ilaris in a paid claim through a pharmacy or medical benefit in the previous 120 days? ❑ Yes ❑ No

8. Please provide the following information:
   ❑ Total duration of treatment (approximate duration is acceptable): _____ months
   ❑ Date of the last dose administered: _____
   ❑ Approving health plan/pharmacy benefit manager: _____
   ❑ Date of the prior authorization/approval: _____
   ❑ Prior authorization/approval number (if any): _____

9. *If patient has received at least 3 months of Ilaris*, has the patient achieved or maintained positive clinical response to treatment as evidenced by one of the following? ***Indicate below and no further questions.***
   ❑ Yes – Low disease activity
   ❑ Yes – Improvement in signs and symptoms
   ❑ Yes – Maintenance of improvement in signs and symptoms
   ❑ No

10. Has the patient received at least a 28-day supply of Kineret or Actemra through a prior authorization process for a pharmacy or medical benefit in the previous 120 days? ❑ Yes ❑ No

11. Has the patient received or experienced an inadequate response to ANY of the following?
    ❑ At least 2 weeks of treatment with corticosteroids (e.g. prednisone, methylprednisolone)
    ❑ At least 3 months of treatment with methotrexate
    ❑ At least 3 months of treatment with leflunomide
    ❑ No – No history of an inadequate response to any of the above

Section B: Gout

12. Is Ilaris being prescribed to treat acute gout attacks? ❑ Yes ❑ No

13. Is the patient currently receiving Ilaris? ❑ Yes ❑ No *If No, skip to #15*

14. Has the patient experienced at least one of the following treatment responses with a prior treatment with Ilaris? ***Indicate below and no further questions.***
    ❑ Yes – Reduction in swelling within 72 hours
    ❑ Yes – Reduction in pain compared to prior attacks
    ❑ Yes – Delayed time to flare compared to prior attacks
    ❑ No

15. How many gout flares has the patient had within the previous 12 months? _____

16. Has the patient had an inadequate response or intolerance at previous attacks, or contraindication to at least two of the following? ***Indicate <u>all</u> 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
    ❑ None of the above

17. Will the patient receive Ilaris concurrently with urate-lowering therapy (i.e., allopurinol or febuxostat)?
    ❑ 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)**