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.

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* ❑ *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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Ilaris SGM 1801-A – 03/2022.

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) associated with an increased risk of tuberculosis? *If Yes, skip to #8* ❑ 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? ❑ Yes ❑ No

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

7. Which of the following applies to the patient?
   ❑ Patient has latent TB and treatment for latent TB has been initiated
   ❑ Patient has latent TB and treatment for latent TB has been completed
   ❑ Patient has latent TB and treatment for latent TB has not been initiated
   ❑ Patient has active TB

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

9. 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

10. 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

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

12. Which of the following diagnoses does the patient have?
    ❑ Familial cold auto-inflammatory syndrome (FCAS)
    ❑ Muckle-Wells syndrome (MWS), *skip to #14*
    ❑ None

13. 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*

14. 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)

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

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

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

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

Section C: Familial Mediterranean Fever

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

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

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Ilaris SGM 1801-A – 03/2022.

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

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

Section D: Systemic Juvenile Idiopathic Arthritis

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

24. 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

25. 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

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

27. 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

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

29. 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

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

Section F: Adult-Onset Still's Disease (AOSD)

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

32. 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

33. 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)**

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Ilaris SGM 1801-A – 03/2022.