Ilaris

Prior Authorization Request

CVS Caremark administers the medical drug prior authorization program on behalf of Harvard Pilgrim Health Care. Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to CVS Caremark, toll-free at 1-844-851-0882** to initiate the review process. If you have questions regarding the prior authorization please contact CVS Caremark at **1-844-387-1435.**

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: _____ **NPI#:** _____
Specialty: _____ **HPHC Provider ID**_____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Rendering Provider Info: ❑ **Same as Requesting Provider** **HPHC Provider ID:**_____
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____ **Provider Tax ID:** _____

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

Additional Demographic Information:

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*

Drug Information:
*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_____ *Route of administration*_____
*Dosing frequency*_____

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? _____

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-844-851-0882

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

Section A: Systemic Juvenile Idiopathic Arthritis (sJIA)

3. Has the patient been diagnosed active with active systemic juvenile idiopathic arthritis (sJIA)?
   ❑ Yes ❑ No *If No, skip to #7*

4. 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

5. 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): _____

6. *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

7. 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

8. 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

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

10. Is the patient currently receiving Ilaris? ❑ Yes ❑ No *If No, skip to #12*

11. 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

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

13. 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

14. Will the patient receive Ilaris concurrently with urate-lowering therapy (i.e., allopurinol or febuxostat)?
    ❑ Yes ❑ No

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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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