pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

ILARIS (canakinumab) (non-preferred) PRIOR AUTHORIZATION FORM

Cytokine and CAM Antagonists and **Quantity Limits/Daily Dose Limits** prior authorization guidelines are accessible on the Department's Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested:	☐Ilaris 150 mg/ml subcutaneous injection vial ☐Ilaris 180 mg subcutaneous injection vial ☐Ilaris _____	# of vials:	Refills:
Dose: _____ mg	Frequency: ☐every 4 weeks ☐every 8 weeks ☐other *(specify)*: _____		
Recipient weight: _____ lbs/kg	Diagnosis:	Dx code (required):	

Specialty Pharmacy Drug Program: Ilaris is part of the DHS Specialty Pharmacy Drug Program and is only available from one of the two DHS specialty pharmacies – **Walgreen's Specialty Pharmacy.**

INITIAL request – complete questions applicable to recipient's diagnosis

1. Check all that apply to the recipient and *submit documentation for each*.
   - ☐vaccinated for hepatitis B
   - ☐screened for hepatitis B (surface antigen & core antibody)
   - ☐up-to-date with all age-appropriate immunizations
   - ☐screened for tuberculosis

2. Does the recipient have one of the following diagnoses? *(Check applicable diagnosis.)*
   - ☐periodic fever syndrome
     - ☐cryopyrin-associated periodic syndrome (CAPS)
       - ☐familial cold autoinflammatory syndrome (FCAS)
       - ☐Muckle-Wells syndrome (MWS)
     - ☐familial Mediterranean fever (FMF)
     - ☐hyperimmunoglobulin D syndrome/mevalonate kinase deficiency (HIDS/MKD)
     - ☐TNF receptor-1 associated periodic syndrome (TRAPS)
   - ☐systemic juvenile idiopathic arthritis (sJIA)

   ☐Yes *Submit all supporting documentation of differential diagnosis.*

   ☐No *Submit documentation supporting the use of Ilaris for the recipient's diagnosis.*

3. ***For a diagnosis other than the approved indication(s),*** submit documentation supporting the use of the requested medication for the recipient's diagnosis & other treatments tried.

RENEWAL request

1. While on Ilaris, did the recipient experience improvement in disease activity and/or level of functioning?

   ☐Yes ☐No *Submit documentation of recipient's response to therapy.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: