

ILARIS (canakinumab) 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	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info (PA#: _____)	Prescriber name:	
<input type="checkbox"/> Renewal request	# of pages in request: _____		
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: <input type="checkbox"/> Ilaris 150 mg/ml subcutaneous injection	Quantity:	Refills:
Dose: _____ mg	Frequency: <input type="checkbox"/> every 4 weeks <input type="checkbox"/> every 8 weeks <input type="checkbox"/> other (specify): _____	
Recipient weight: _____ lbs/kg	Diagnosis:	Dx code (required):
1. Specialty Pharmacy Drug Program: What Specialty Pharmacy will be used? <input type="checkbox"/> Diplomat Specialty <input type="checkbox"/> Walgreens Specialty		
2. Check all that apply to the Recipient and <u>submit documentation for each</u> . <input type="checkbox"/> screened for hepatitis B (antibody and/or surface antigen) <input type="checkbox"/> screened for tuberculosis <input type="checkbox"/> up-to-date with all age-appropriate immunizations (if < 21 years of age, in accordance with EPSDT guidelines)		
3. Does the Recipient have one of the following diagnoses? (Check applicable diagnosis.)		<input type="checkbox"/> Yes <u>Submit all supporting documentation of differential diagnosis.</u> <input type="checkbox"/> No <u>Submit documentation supporting the use of Ilaris for the Recipient's diagnosis</u>
<input type="checkbox"/> periodic fever syndrome <input type="checkbox"/> cryopyrin-associated periodic syndrome (CAPS) <input type="checkbox"/> familial cold autoinflammatory syndrome (FCAS) <input type="checkbox"/> Muckle-Wells syndrome (MWS) <input type="checkbox"/> familial Mediterranean fever (FMF) <input type="checkbox"/> hyperimmunoglobulin D syndrome/mevalonate kinase deficiency (HIDS/MKD) <input type="checkbox"/> TNF receptor-1 associated periodic syndrome (TRAPS) <input type="checkbox"/> systemic juvenile idiopathic arthritis (sJIA)		
4. Renewal requests only: While on Ilaris, has the Recipient experienced improvement in disease activity and/or level of functioning?		<input type="checkbox"/> Yes <u>Submit documentation of Recipient's response to therapy.</u> <input type="checkbox"/> No

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

Prescriber Signature:	Date:
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