Ilaris

CareFirst 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*

What is the ICD-10 code? _____

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

Criteria Questions:

1. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Otezla, Xeljanz)?
❒ Yes, *Continue to 2*
❒ No, *Continue to 2*

2. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis?
❒ Yes, *Continue to 6*
❒ No, *Continue to 3*

3. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [TST], interferon-release assay [IGRA]) within 12 months of initiating therapy?
❒ Yes, *Continue to 4*
❒ No, *Continue to 4*

4. What were the results of the tuberculosis (TB) test?

❒ Positive for TB, *Continue to 5*

❒ Negative for TB, *Continue to 6*

❒ Unknown, *No further questions*

5. Which of the following applies to the patient?

❒ Patient has latent TB and treatment for latent TB has been initiated, *Continue to 6*

❒ Patient has latent TB and treatment for latent TB has been completed, *Continue to 6*

❒ Patient has latent TB and treatment for latent TB has not been initiated, *Continue to 6*

❒ Patient has active TB, *Continue to 6*

6. What is the patient's diagnosis?
❒ Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS), *Continue to 7*

❒ Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS), *Continue to 16*

❒ Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD), *Continue to 24*

❒ Familial Mediterranean Fever (FMF), *Continue to 31*

❒ Systemic juvenile idiopathic arthritis (sJIA), *Continue to 39*

❒ Polyarticular juvenile idiopathic arthritis (pJIA), *No further questions*

❒ Gout flares, *Continue to 48*

❒ Pseudogout (also known as calcium pyrophosphate deposition disease) flares, *Continue to 49*

❒ Adult-onset Still's disease (AOSD), *Continue to 58*

❒ Other, please specify. _____, *No further questions*

7. Is the patient 4 years of age or older?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. Is the requested drug being prescribed by or in consultation with a rheumatologist or immunologist?
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 10*
❒ No, *Continue to 12*

10. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 12*

❒ No, *Continue to 11*

❒ Unknown, *Continue to 12*

11. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

12. What is the patient's diagnosis?

❒ Familial cold autoinflammatory syndrome (FCAS), *Continue to 13*

❒ Muckle-Wells syndrome (MWS), *Continue to 14*

❒ None, *No further questions*

13. Does the patient have classic signs and symptoms of familial cold autoinflammatory syndrome (FCAS) (i.e., recurrent, intermittent fever and rash that were often exacerbated by exposure to generalized cool ambient temperature)?
❒ Yes, *Continue to 15*
❒ No, *Continue to 15*

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, *Continue to 15*
❒ No, *Continue to 15*

15. Does the patient have functional impairment limiting the activities of daily living?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

16. Is the requested drug being prescribed by or in consultation with a rheumatologist or immunologist?
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 18*
❒ No, *Continue to 20*

18. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 20*

❒ No, *Continue to 19*

❒ Unknown, *Continue to 20*

19. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

20. Does the patient have chronic or recurrent disease activity?
❒ Yes, *Continue to 21*
❒ No, *Continue to 21*

21. Has the patient had active flares within the last 6 months? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation indicating number of active flares within the last 6 months. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 22*
❒ No, *Continue to 22*

22. What is the patient's Physician's Global Assessment (PGA) score? ***ACTION REQUIRED***: Please attach chart notes or medical record documentation indicating Physician's Global Assessment score.

❒ Less than 2, ***ACTION REQUIRED****: Submit supporting documentation, Continue to 23*

❒ 2 or greater, ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ Unknown, *Continue to 23*

23. What is the patient's C-reactive protein (CRP) level in mg/L? ***ACTION REQUIRED***: Please attach laboratory result indicating patient's C-reactive protein (CRP) level.

❒ 10 mg/L or less, ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ Greater than 10 mg/L, ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ Unknown, *No further questions*

24. Is the requested drug being prescribed by or in consultation with a rheumatologist or immunologist?
❒ Yes, *Continue to 25*
❒ No, *Continue to 25*

25. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 26*
❒ No, *Continue to 28*

26. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 28*

❒ No, *Continue to 27*

❒ Unknown, *Continue to 28*

27. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

28. Has the patient had active flares within the last 6 months? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation indicating number of active flares within the last 6 months. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 29*
❒ No, *Continue to 29*

29. What is the patient's Physician's Global Assessment (PGA) score? ***ACTION REQUIRED***: Please attach chart notes or medical record documentation indicating Physician's Global Assessment score.

❒ Less than 2, ***ACTION REQUIRED****: Submit supporting documentation, Continue to 30*

❒ 2 or greater, ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ Unknown, *Continue to 30*

30. What is the patient's C-reactive protein (CRP) level in milligrams per liter (mg/L) ***ACTION REQUIRED***: Please attach laboratory result indicating patient's C-reactive protein (CRP) level.

❒ 10 mg/L or less, ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ Greater than 10 mg/L, ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ Unknown, *No further questions*

31. Is the requested drug being prescribed by or in consultation with a rheumatologist or immunologist?
❒ Yes, *Continue to 32*
❒ No, *Continue to 32*

32. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 33*
❒ No, *Continue to 35*

33. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 35*

❒ No, *Continue to 34*

❒ Unknown, *Continue to 35*

34. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

35. Does the patient have active disease with flares within the last 6 months? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation indicating number of active flares within the last 6 months. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 36*
❒ No, *Continue to 36*

36. What is the patient's C-reactive protein (CRP) level in mg/L? ***ACTION REQUIRED***: Please attach laboratory result indicating patient's C-reactive protein (CRP) level.

❒ 10 mg/L or less, ***ACTION REQUIRED****: Submit supporting documentation, Continue to 37*

❒ Greater than 10 mg/L, ***ACTION REQUIRED****: Submit supporting documentation, Continue to 37*

❒ Unknown, *Continue to 37*

37. Has the patient had an inadequate response or intolerance to colchicine? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 38*

38. Does the patient have a contraindication to colchicine? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

39. Is the patient 2 years of age or older?
❒ Yes, *Continue to 40*
❒ No, *Continue to 40*

40. Is the requested drug being prescribed by or in consultation with a rheumatologist?
❒ Yes, *Continue to 41*
❒ No, *Continue to 41*

41. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 42*
❒ No, *Continue to 45*

42. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 45*

❒ No, *Continue to 43*

❒ Unknown, *Continue to 45*

43. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?
❒ Yes, *Continue to 44*
❒ No, *Continue to 44*

44. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED***: Please attach chart notes or medical record documentation supporting positive clinical response.
❒ Number of joints with active arthritis (e.g., swelling, pain, limitation of motion), ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Number of joints with limitation of movement, ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ Functional ability, ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Systemic features (e.g., fevers, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly, or serositis), ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ None of the above, *No further questions*

45. Has the patient been diagnosed with active systemic juvenile idiopathic arthritis (sJIA)?
❒ Yes, *Continue to 46*
❒ No, *Continue to 46*

46. Has the patient ever received or is currently receiving a biologic (e.g., Humira) indicated for treatment of active systemic juvenile idiopathic arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 47*

47. Does the patient have active systemic features (e.g., fever, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly, or serositis)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

48. Is the patient an adult (18 years of age or older)?
❒ Yes, *Continue to 49*
❒ No, *Continue to 49*

49. Is the requested drug being requested for the treatment of flares for gout or pseudogout (also known as calcium pyrophosphate deposition disease)?
❒ Yes, *Continue to 50*
❒ No, *Continue to 50*

50. Is the requested drug being prescribed by or in consultation with a rheumatologist?
❒ Yes, *Continue to 51*
❒ No, *Continue to 51*

51. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 52*
❒ No, *Continue to 54*

52. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 54*

❒ No, *Continue to 53*

❒ Unknown, *Continue to 54*

53. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

54. Has the patient experienced at least three flares in the last 12 months?
❒ Yes, *Continue to 55*
❒ No, *Continue to 55*

55. Has the patient had an inadequate response to non-steroidal anti-inflammatory drugs (NSAIDs) or has an intolerance or contraindication to NSAIDs? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, please attach documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 56*
❒ No, *Continue to 56*

56. Has the patient had an inadequate response to colchicine or has an intolerance or contraindication to colchicine? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, please attach documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 57*
❒ No, *Continue to 57*

57. Has the patient had an inadequate response to corticosteroids or has an intolerance or contraindication to corticosteroids? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. If therapy is not advisable, please attach documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

58. Is the patient an adult (18 years of age or older)?
❒ Yes, *Continue to 59*
❒ No, *Continue to 59*

59. Is the requested drug being prescribed by or in consultation with a rheumatologist?
❒ Yes, *Continue to 60*
❒ No, *Continue to 60*

60. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 61*
❒ No, *Continue to 64*

61. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 64*

❒ No, *Continue to 62*

❒ Unknown, *Continue to 64*

62. Has the patient achieved or maintained a positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?
❒ Yes, *Continue to 63*
❒ No, *Continue to 63*

63. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED***: Please attach chart notes or medical record documentation supporting a positive clinical response.
❒ Number of joints with active arthritis (e.g., swelling, pain, limitation of motion), ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Number of joints with limitation of movement, ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ Functional ability, ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ Systemic features (e.g., fevers, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly, or serositis), ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ None of the above, *No further questions*

64. Has the patient ever received or is currently receiving a biologic indicated for treatment of active adult-onset Still's disease (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 65*

65. Does the patient have active systemic features (e.g., fever, arthralgia/arthritis, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly, or sore throat)?
❒ Yes, *Continue to 66*
❒ No, *Continue to 66*

66. Has the patient experienced an inadequate response to a trial of nonsteroidal anti-inflammatory drugs (NSAIDs), corticosteroids, or a conventional synthetic drug (e.g., methotrexate)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

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

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