Member Name: {{MEMFIRST}} {{MEMLAST}} **DOB:** {{MEMBERDOB}} **PA Number:** {{PANUMBER}}

{{PANUMCODE}}

{{DISPLAY_PAGNAME}}
{{PACDESCRIPTION}}

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to {{COMPANY_NAME}} at {{CLIENT_PAG_FAX}}. Please contact {{COMPANY_NAME}} at {{CLIENT_PAG_PHONE}} with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of {{DRUGNAME}}.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}} **Patient Phone:** <<MEMPHONE>>
Specialty: _____ **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Physician Office Address: <<PHYADDRESS1>> <<PHYADDRESS2>> <<PHYCITY>>, <<PHYSTATE>> <<PHYZIP>>
Drug Name: {{DRUGNAME}}

Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: <<DIAGNOSIS>> **ICD Code**: <<ICD9>>

1. What is the prescribed dose and frequency?
   ❑ Kineret 100mg Quantity and Frequency: _____
   ❑ Other: _____

2. What is the diagnosis?
   ❑ Moderately to severely active rheumatoid arthritis (RA)
   ❑ Adult-onset Still's disease (AOSD)
   ❑ Active systemic juvenile idiopathic arthritis (sJIA)
   ❑ Recurrent pericarditis
   ❑ Multicentric Castleman disease
   ❑ Schnitzler syndrome
   ❑ Polyarticular juvenile idiopathic arthritis
   ❑ Gout flares
   ❑ Deficiency of interleukin-1 receptor antagonist (DIRA)
   ❑ Erdheim-Chester disease
   ❑ Cryopyrin-associated periodic syndromes (CAPS), including neonatal-onset multisystem inflammatory disease (NOMID) (also known as chronic infantile neurologic cutaneous and articular syndrome [CINCA])
   ❑ Hyperimmunoglobulin D syndrome (HIDS)/Mevalonate kinase deficiency (MKD)
   ❑ Pseudogout (also known as calcium pyrophosphate deposition disease)
   ❑ Chimeric antigen receptor (CAR) T-cell related toxicities - Cytokine release syndrome (CRS)
   ❑ Other _____

3. What is the ICD-10 code? _____

4. What is the patient's body weight? _____ kg/lbs (circle one)

5. *If the diagnosis is adult-onset Still's disease (AOSD), active systemic juvenile idiopathic arthritis (sJIA), recurrent pericarditis, multicentric Castleman's disease, hyperimmunoglobulin D Syndrome (HIDS)/mevalonate kinase deficiency (MKD), Schnitzler's syndrome, gout flares*, *CAR T-cell related toxicities, or Erdheim-Chester Disease,* is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)? ❑ Yes ❑ No ❑ N/A - diagnosis is not listed above

Section A: All Requests

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 ❑ No

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?
   If Yes, skip to #6 ❑ Yes ❑ No

3. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [TST], interferon-release assay [IGRA]) within 6 months of initiating therapy? ❑ Yes ❑ No

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

5. 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

6. Is the requested drug being prescribed by or in consultation with any of the following?
   ❑ Cardiologist ❑ Dermatologist ❑ Hematologist ❑ Immunologist ❑ Oncologist ❑ Rheumatologist
   ❑ None of the above

7. Is this request for continuation of therapy with the requested drug?
   ❑ Yes ❑ No *If No, skip to diagnosis section.*

8. 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, or diagnosis is Rheumatoid arthritis, skip to diagnosis section.* ❑ Yes ❑ No ❑ Unknown

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

Section B: Rheumatoid Arthritis

Continuation

1. Has the patient achieved or maintained a positive clinical response since starting treatment with the requested drug? ❑ Yes ❑ No

2. Has the patient experienced substantial disease activity improvement (e.g., at least 20% from baseline) in tender joint count, swollen joint count, pain, or disability? ***ACTION REQUIRED: Please attach chart notes or medical record documentation supporting a positive clinical response.*** ❑ Yes ❑ No

Initiation

3. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) indicated for the treatment of moderately to severely active rheumatoid 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 and no further questions. ❑ Yes ❑ No

4. Does the patient meet either of the following: a) the patient was tested for the rheumatoid factor (RF) biomarker and the RF biomarker test was positive, or b) the patient was tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker and the anti-CCP biomarker test was positive? ***ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing and skip to #8.*** ❑ Yes ❑ No

5. Has the patient been tested for all of the following biomarkers: a) rheumatoid factor (RF), b) anti-cyclic citrullinated peptide (anti-CCP), and c) C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR)? ***ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing.*** ❑ Yes ❑ No

6. Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate at a dose greater than or equal to 15 mg per week? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and no further questions.*** ❑ Yes ❑ No

7. Has the patient experienced intolerance to methotrexate? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and no further questions.*** ❑ Yes ❑ No

8. Does the patient have a contraindication to methotrexate? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No

9. Please indicate the contraindication to methotrexate.
   ❑ Hypersensitivity ❑ History of intolerance or adverse event
   ❑ Drug interaction ❑ Risk of treatment-related toxicity
   ❑ Breastfeeding ❑ Pregnancy or currently planning pregnancy
   ❑ Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease
   ❑ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension) ❑ Other, please specify. _____

Section C: Adult-Onset Still's Disease

Continuation

1. 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) ❑ Functional ability
   ❑ Number of joints with limitation of movement
   ❑ Systemic features (e.g., fevers, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly, or serositis)
   ❑ None of the above

Initiation

2. 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 and no further questions.*** ❑ Yes ❑ No

3. Does the patient have active systemic features (e.g., fever, arthralgia/arthritis, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly, or sore throat)? ❑ Yes ❑ No

4. 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)? ❑ Yes ❑ No

Section D: Systemic Juvenile Idiopathic Arthritis

Continuation

1. 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)
   ❑ Number of joints with limitation of movement
   ❑ Functional ability
   ❑ Systemic features (e.g., fevers, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly, or serositis)
   ❑ None of the above

Initiation

2. 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 and no further questions.***
   ❑ Yes ❑ No

3. Does the patient have active systemic features (e.g., fever, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly, or serositis)? ❑ Yes ❑ No

4. Has the patient had an inadequate response to non-steroidal anti-inflammatory drugs (NSAIDs) or systemic glucocorticoids? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.*** ❑ Yes ❑ No

Section E: Cryopyrin-Associated Periodic Syndromes (CAPS), including Neonatal-Onset Multisystem Inflammatory Disease (NOMID)

Continuation

1. 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.
   ❑ Fever
   ❑ Skin rash
   ❑ Joint pain and/or inflammation
   ❑ Central nervous system (CNS) symptoms (e.g., meningitis, headache, cerebral atrophy, uveitis, hearing loss)
   ❑ Inflammatory markers (e.g., serum amyloid A [SAA], C-reactive protein [CRP], erythrocyte sedimentation rate [ESR])
   ❑ None of the above

Section F: Recurrent Pericarditis

Continuation

1. Has the patient achieved or maintained a positive clinical response as evidenced by decreased recurrence of pericarditis? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting a positive clinical response and no further questions.*** ❑ Yes ❑ No

2. Has the patient achieved or maintained a positive clinical response as evidenced by improvement in signs and symptoms of the condition since starting treatment with the requested drug? ❑ Yes ❑ No

3. 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.
   ❑ Pericarditic or pleuritic chest pain ❑ Pericardial effusion ❑ Pericardial or pleural rubs
   ❑ C-reactive protein (CRP) ❑ Electrocardiogram (ECG) ❑ None of the above

Initiation

4. Has the patient had at least two episodes of pericarditis? ❑ Yes ❑ No

5. Has the patient failed at least two agents of standard therapy (e.g., colchicine, non-steroidal anti-inflammatory drugs [NSAIDs], corticosteroids)? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.***
   ❑ Yes ❑ No

Section G: Multicentric Castleman Disease

1. Will the requested drug be used as a single-agent? ❑ Yes ❑ No

2. Has the disease progressed following treatment of relapsed, refractory or progressive disease? ❑ Yes ❑ No

Section H: Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD)

1. 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.***
   ❑ Yes ❑ No

2. What is the patient's Physician's Global Assessment (PGA) score? Indicate score. ***ACTION REQUIRED: Please attach chart notes or medical record documentation indicating Physician's Global Assessment score.***
   _____ ❑ Unknown *If greater than or equal to 2, no further questions.*

3. What is the patient's C-reactive protein (CRP) level in milligrams per liter (mg/L)? Indicate in mg/L.
   ACTION REQUIRED: Please attach laboratory result indicating patient's C-reactive protein (CRP) level.
   ❑ 10 mg/L or less_____ ❑ Greater than 10 mg/L_____ ❑ Unknown

Section I: Schnitzler Syndrome

1. Does the patient have an urticarial rash and monoclonal IgM (or IgG) gammopathy? ❑ Yes ❑ No
2. Does the patient have at least 2 of the following signs and symptoms: A) Fever, B) Joint pain or inflammation, C) Bone pain, D) Lymphadenopathy, E) Hepatomegaly or splenomegaly, F) Leukocytosis, G) Elevated erythrocyte sedimentation rate (ESR), H) abnormalities on bone morphological study (e.g., increased bone density)? ❑ Yes ❑ No
3. Have other possible causes of the signs and symptoms been ruled out, including but not limited to: hyperimmunoglobulin D syndrome, adult-onset Still's disease, urticarial hypocomplementemic vasculitis, acquired C1 inhibitor deficiency and cryoglobulinemia? ❑ Yes ❑ No

Section J: Gout/Pseudogout Flares

1. Has the patient experienced at least three flares in the last 12 months? ❑ Yes ❑ No
2. 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.*** ❑ Yes ❑ No
3. 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.*** ❑ Yes ❑ No
4. Has the patient had an inadequate response to corticosteroids or 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 and no further questions.*** ❑ Yes ❑ No

Section K: Deficiency of Interleukin-1 Receptor Antagonist (DIRA)

1. Has the diagnosis of deficiency of interleukin-1 receptor antagonist (DIRA) been genetically confirmed? ❑ Yes ❑ No
2. Does the patient have *IL1RN* mutations? ***ACTION REQUIRED: If Yes, please attach documentation of IL1RN mutation status.*** ❑ Yes ❑ No

Section L: Chimeric Antigen Receptor (CAR) T-Cell Related Toxicities

1. Does the patient have CAR T-cell induced cytokine release syndrome that is refractory to high-dose corticosteroids and anti-IL-6 (anti-interleukin-6) therapy (e.g., Actemra)? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.*** ❑ Yes ❑ No
2. Will the requested drug be used as a replacement for the second dose of tocilizumab when supplies are limited or unavailable? ❑ Yes ❑ No

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date