Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS (MEDICAID)

Ilaris (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-855-684-5250**.
When conditions are met, we will authorize the coverage of Ilaris (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Ilaris (canakinumab)

Other, please specify_____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis:_____ ICD Code:_____

Please circle the appropriate answer for each question.

1. Has this plan authorized Ilaris in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 4.]

2. Is the prescribed dose within the FDA-approved dosing (based on weight)? Y N

   Please document current weight: _____

   [If no, then no further questions.]

3. Has the patient had at least a 20% improvement in symptoms? Y N

[No further questions.]

4. Does the patient have juvenile idiopathic arthritis (JIA)? Y N

   [If no, skip to question 10.]

5. Does the patient have the systemic subtype of JIA with currently ACTIVE systemic features? Y N

   Note: Systemic features such as fever, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly, or serositis.

   Note: Ilaris has not been studied in patients who do not have active systemic features.

   [If no, then no further questions.]

6. Did the patient continue to have synovitis in more than one joint despite use of methotrexate or leflunomide for at least 1 month? Y N

   [If yes, skip to question 8.]

7. Does the patient have contraindications to methotrexate and leflunomide? Y N

   Note: Contraindications such as Pregnancy, alcoholism, Chronic liver disease, Leukopenia, thrombocytopenia, or anemia.

   If yes, please document contraindication:_____

   [If no, then no further questions]

8. Did the patient continue to have synovitis in more than one joint despite use of Kineret or Actemra for at least 1 month? Y N

   Note: Both Kineret and Actemra require prior authorization.

   [If no, then no further questions.]

9. Is the patient at least 2 years of age and at least 7.5kg? Y N

   Please document current weight: _____

   [If no, then no further questions.]

   [If yes, skip to question14.]

10. Does the patient have a diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS)? Y N

[If no, then no further questions.]

11. Has the diagnosis been confirmed by a positive genetic test for the NALP3, CIAS1, or NLRP3 mutation(s)? Y N

    [If no, then no further questions.]

12. Has the patient failed a minimum 3-month trial of Kineret? Y N

    [If no, then no further questions.]

13. Is the patient at least 4 years of age and at least 15kg? Y N

    Please document current weight: _____

    [If no, then no further questions.]

14. Is Ilaris being prescribed by, or in consultation with a rheumatologist? Y N

    [If no, then no further questions.]

15. Has the patient been screened for latent tuberculosis (TB) and hepatitis B? Y N

    [If no, then no further questions.]

16. Does the patient have an active infection (including Hepatitis B and/or tuberculosis (TB)? Y N

    [If no, skip to question 18.]

17. Is the patient currently receiving or has completed treatment for latent TB infection or Hepatitis B? Y N

    [If no, then no further questions.]

18. Will Ilaris be given in combination with another biologic DMARD? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date