

OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY/MEDICAL PRIOR AUTHORIZATION REQUEST

Directions: *The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-844-723-2094. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.*

Drug Requested: **Ilaris®** (canakinumab) **(J0638)** *(Medical)*

{Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS), Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD), and Familial Mediterranean Fever (FMF)}

DRUG INFORMATION: Complete all information below or authorization process will be delayed.

Drug Form/Strength/Quantity: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code: _____

CLINICAL CRITERIA: Progress notes/chart notes **MUST** be submitted to support lab values and diagnosis. Applicable boxes below **must** be checked to ensure the authorization process will **NOT** be delayed.

1st Approval: 6 months

Age: ≥ 2 years old _____ Weight kg: _____

Diagnosis:

Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS)

- Chart notes documenting six (6) flares within a 12 month time frame.
- Labs document CRP >10mg/L

Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD)

- Test result submitted genetic MVK/enzymatic (MKD)
- History \geq three (3) febrile acute flares within a 6 month period and not receiving prophylactic treatment:
 YES NO
- \geq CRP 10 mg/L

Familial Mediterranean Fever (FMF)

- Documented a trial and failure colchicine 1.5-2.0mg/day
- Type I phenotype
- Currently active disease the following will meet the criteria:
 - One (1) flare per month (chart notes document five months of flare)
 - \geq CRP 10 mg/L

Reauthorization Approval: 1 year:

Please submit current progress notes that document CRP and symptoms.

(signature on next page)

Medication being provided by a Specialty Pharmacy: Sentara Norfolk General CM Pharmacy

****Use of samples to initiate therapy does not meet step edit/preauthorization criteria.****

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: 7/1/2018