OPTIMA HEALTH COMMUNITY CARE

(MEDICAID)

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 1-844-348-3720.** 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 qualify. If incomplete, authorization process will be delayed.

Initial 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 ≥ three (3) febrile acute flares within a 6 month period and not receiving prophylactic treatment ❑ **YES** ❑ **NO**
- ❑ ≥ 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)
  - ❑ ≥ CRP 10 mg/L

(continued on next page)

Reauthorization Approval - 1 year. (Please submit current progress notes that document CRP and symptoms.)

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: ~~8/1/2017~~; 8/31/2017; ~~8/22/2018~~; ~~10/8/2018~~; **(Reformatted) 2/5/2019**