OPTIMA HEALTH COMMUNITY CARE

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. If incomplete, 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.

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 ≥ 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

Reauth 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: 8/1/2017; **8/31/2017**;