OPTIMA HEALTH PLAN

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 1-844-202-5034. 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 or authorization process could be delayed.

1st Approval: 6 months

Age: ❑ ≥ 2 years old ❑ **Weight kg:** _____

Please check all that apply: **(All boxes must be checked)** ***1st Approval: 6 months***

Age: ❑ ≥ 2 years old ❑ **Weight kg:** _____

Diagnosis: Check applicable box below for 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 and must be submitted along with 1st page)

Medication being provided by a Specialty Pharmacy - Briova SpecialtyRx

*****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 #: _____

***Approved by Pharmacy and Therapeutics Committee**: 11/18/16
REVISED/UPDATED: ~~3/28/2017; 4/4/2017; 9/14/2017;~~ **10/4/2017**;