Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Ilaris (canakinumabl) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorization: 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Ilaris (canakinumabl).** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at: http://pithelp.appl.kp.org/MAS/formulary.html**

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Provider Name: _____ Specialty: _____ Provider NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

Please check the boxes that apply:
□ Initial Request □ Continuation of Therapy Request

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is the medication is being used for one of these indications?
   Periodic Fever Syndromes: □ Cryopyrin-Associated Periodic Syndromes (CAPS) □ Familial Cold Autoinflammatory Syndrome (FCAS) □Muckle-Wells Syndrome (MWS)

   □ Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS)

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

   □ Familial Mediterranean Fever (FMF)

If #1 does not apply, please fill out the rest of this form

2. Does the member have diagnosis of one of the following? **AND**
   □ Juvenile Idiopathic Arthritis (JIA)

   □ Other: _____

3. Was there therapeutic failure on oral methotrexate? **AND**
   □ No □ Yes

4. Was there therapeutic failure to one of the preferred agents? (e.g. Enbrel, Humira) **AND**
   □ No □ Yes

5. If this is being used for Systemic Juvenile Idiopathic Arthritis (SJIA):
   a. Is the patient ≥2 years old?
      □ No □ Yes

6 – Provider Sign-Off

Additional Information – Please provide any additional information that should be taken into consideration.

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**