OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Ilaris® Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			**Provider Information** (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Periodic fever syndromes
❑ Systemic juvenile idiopathic arthritis (SJIA)
❑ Other diagnosis: ___________________________ ICD-10 Code(s): ___________________________

For periodic fever syndromes, answer the following:

Select if the patient has one of the following periodic fever syndromes:
- ❑ Cryopyrin-associated periodic syndromes (CAPS), including familial cold autoinflammatory syndrome (FCAS) and Muckle-Wells syndrome (MWS)
- ❑ Tumor necrosis factor receptor associated periodic syndrome (TRAPS)
- ❑ Hyperimmunoglobulin D (Hyper-IgD) syndrome (HIDS)/Mevalonate kinase deficiency (MKD)
- ❑ Familial Mediterranean fever (FMF)

Select if Ilaris is prescribed by or in consultation with one of the following specialists:
- ❑ Allergist
- ❑ Dermatologist
- ❑ Immunologist
- ❑ Neurologist
- ❑ Rheumatologist
- ❑ Other medical specialist

Select if the patient will be receiving Ilaris in combination with the following:
- ❑ Tumor necrosis factor (TNF) inhibitors (e.g., Enbrel [etanercept], Humira [adalimumab], Remicade [infliximab])
- ❑ Interleukin-1 inhibitor (e.g., Arcalyst [rilonacept], Kineret [anakinra])

For systemic juvenile idiopathic arthritis (SJIA), answer the following:

Does the patient have active SJIA? ❑ **Yes** ❑ **No**

Has the patient had trial and failure, contraindication, or intolerance to corticosteroids, methotrexate, or non-steroidal anti-inflammatory drugs (NSAIDs)? ❑ **Yes** ❑ **No**

Select if the patient will be receiving Ilaris in combination with the following:
- ❑ Tumor necrosis factor (TNF) inhibitors (e.g., Enbrel [etanercept], Humira [adalimumab], Remicade [infliximab])
- ❑ Interleukin-1 inhibitor (e.g., Arcalyst [rilonacept], Kineret [anakinra])

Reauthorization:
If this is a reauthorization request, answer the following questions:

Is there documentation the patient has had a positive clinical response to Ilaris therapy? ❑ **Yes** ❑ **No**

Select if the patient will be receiving Ilaris in combination with the following:
- ❑ Tumor necrosis factor (TNF) inhibitors (e.g., Enbrel [etanercept], Humira [adalimumab], Remicade [infliximab])
- ❑ Interleukin-1 inhibitor (e.g., Arcalyst [rilonacept], Kineret [anakinra])

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Ilaris® Prior Authorization Request Form (Page 2 of 2)

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Quantity Limit Requests:

What is the quantity requested per MONTH? ________

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: ____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

____

____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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