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)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
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
  - ❑ Cryopyrin-associated periodic syndromes (CAPS), including familial cold auto-inflammatory syndrome (CAPS) and/or Muckle-Wells syndrome (MWS)
  - ❑ Familial Mediterranean fever (FMF)
  - ❑ Hyperimmunoglobulin D syndrome (HIDS)/Mevalonate kinase deficiency (MKD)
  - ❑ Tumor necrosis factor receptor associated periodic syndrome (TRAPS)
- ❑ Systemic juvenile idiopathic arthritis (SJIA)
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

For cryopyrin-associated periodic syndromes (CAPS), including familial cold auto-inflammatory syndrome (CAPS) and/or Muckle-Wells syndrome (MWS), answer the following:

Has the diagnosis of CAPS been confirmed by NRLP-3 [nucleotide-binding domain, leucine rich family (NLR), pyrin domain containing 3] gene (also known as cold-induced auto-inflammatory syndrome-1 [CIAS1])? ❑ **Yes** ❑ **No**

Does the patient have clinical symptoms (e.g., rash, fever, arthralgia) indicative of active inflammation? ❑ **Yes** ❑ **No**

Does the patient have elevated acute phase reactants (e.g., ESR, CRP) indicative of active inflammation? ❑ **Yes** ❑ **No**

Select if Ilaris is prescribed by or in consultation with one of the following specialists:

❑ Allergist ❑ Immunologist ❑ Rheumatologist
❑ Dermatologist ❑ Neurologist ❑ Other medical specialist

Will the patient use Ilaris in combination with a tumor necrosis factor (TNF) inhibitor [e.g., Enbrel (etanercept), Humira (adalimumab), Remicade (infliximab)]? ❑ **Yes** ❑ **No**

Will the patient use Ilaris in combination with interleukin-1 inhibitors [e.g., Arcalyst (rilonacept), Kineret (anakinra)]? ❑ **Yes** ❑ **No**

For systemic juvenile idiopathic arthritis, answer the following:

Does the patient have active systemic juvenile idiopathic arthritis (e.g., fever, serositis, rash, arthritis)? ❑ **Yes** ❑ **No**

Is Ilaris prescribed by or in consultation with a rheumatologist? ❑ **Yes** ❑ **No**

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

Will the patient use Ilaris in combination with a tumor necrosis factor (TNF) inhibitor [e.g., Enbrel (etanercept), Humira (adalimumab), Remicade (infliximab)]? ❑ **Yes** ❑ **No**

Will the patient use Ilaris in combination with interleukin-1 inhibitors [e.g., Arcalyst (rilonacept), Kineret (anakinra)]? ❑ **Yes** ❑ **No**

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

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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**

Will the patient use Ilaris in combination with a tumor necrosis factor (TNF) inhibitor [e.g., Enbrel (etanercept), Humira (adalimumab), Remicade (infliximab)]? ❑ **Yes** ❑ **No**

Will the patient use Ilaris in combination with interleukin-1 inhibitors [e.g., Arcalyst (rilonacept), Kineret (anakinra)]? ❑ **Yes** ❑ **No**

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
- ❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: _____
- ❑ 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.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
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.