https://providers.amerigroup.com

Ilaris (canakinumab)
Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004
Provider Help Desk 1-800-454-3730

1. PATIENT INFORMATION	**2. PHYSICIAN INFORMATION**
Patient Name: _____	Prescribing Physician: _____
Patient ID #: _____	Physician Address: _____
Patient DOB: _____	Physician Phone #: _____
Date of Rx: _____	Physician Fax #: _____
Patient Phone #: _____	Physician Specialty: _____
Patient Email Address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician Email Address: _____

3. MEDICATION	**4. STRENGTH**	**5. DIRECTIONS**	**6. QUANTITY PER 30 DAYS**
Ilaris (canakinumab)	_____	_____	Specify: _____

7. DIAGNOSIS: _____

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY
NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

□ Yes □ No	Patient has been screened for hepatitis B and C AND it has been confirmed that this patient does NOT have active hepatitis B. Patients with evidence of active Hepatitis B infection (Hepatitis surface antigen positive > 6 months) must have documentation they are receiving or have received effective antiviral treatment
□ Yes □ No	Patient has been treated for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within the last 5 years of starting or resuming treatment with a biological agent. Please Note: Biological agents include: Abatacept (Orencia); Adalimumab (Humira); Anakinra (Kineret); Certolizumab Pegol (Cimzia); Etanercept (Enbrel); Infliximab (Remicade); Golimumab (Simponi); Tocilizumab (Actemra); Ustekinumab (Stelara); Canakinumab (Ilaris); Sarilumab (Kevzara); Secukinumab (Cosentyx).
□ Yes □ No	Patient has a diagnosis of congestive heart failure (CHF) that is New York Heart Association (NYHA) class lll or lV and with an ejection fraction of 50% or less
□ Yes □ No	Patient has been screened for latent TB infection. Please Note: Patients with latent TB will only be considered after one month of TB treatment and patients with active TB will only be considered upon completion of TB treatment.
□ Yes □ No	Patient has had previous trials and therapy failures with two preferred biological agents. Please Note: Preferred biological agents are: Humira, Enbrel, Cosentyx **IF 'Yes', then DOCUMENTATION must be submitted which includes the following:** patient had previous trials and therapy failures with two preferred biological agents. Please Note: Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.

If the requested medication is being used for rheumatoid arthritis (RA):

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□ Yes □ No Patient has a diagnosis of rheumatoid arthritis (RA)

PAGE 1 OF 2, CONTINUED ON PAGE 2

Patient Name: _____ **Patient ID#:** _____

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(For rheumatoid arthritis (RA) – Continued)

□ Yes □ No Patient had a trial and inadequate response to two preferred disease modifying antirheumatic drugs (DMARDs) used concurrently [the combination must include methotrexate plus another preferred oral DMARD (hydroxycholoroquine, sulfasalazine, or leflunomide]. Please Note: The preferred DMARDs are: hydroxycholoroquine, sulfasalazine, and leflunomide,

□ Yes □ No There is evidence that the use of the preferred DMARDs are medically contraindicated
IF 'Yes', then DOCUMENTATION must be submitted which includes the following: documented evidence that the use of the preferred DMARDs would be medically contraindicated. Please Note: Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.

□ Yes □ No Patient had an unsuccessful methotrexate trial

□ Yes □ No There evidence of severe disease documented by radiographic erosions

If the requested medication is being used for moderate to severe psoriatic arthritis:

□ Yes □ No Patient has a diagnosis of moderate to severe psoriatic arthritis

□ Yes □ No Patient has had a trial and inadequate response to the preferred oral DMARD, methotrexate

□ Yes □ No There is evidence that the use of the preferred DMARD, methotrexate, is medically contraindicated
IF 'Yes', then DOCUMENTATION must be submitted which includes the following: documented evidence that the use of the DMARD, methotrexate, is medically contraindicated. Please Note: Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data

□ Yes □ No Patient has had a trial of leflunomide or sulfasalazine, instead of methotrexate

If the requested medication is being used for moderate to severe juvenile idiopathic arthritis:

□ Yes □ No Patient has a diagnosis of moderate to severe juvenile idiopathic arthritis

□ Yes □ No Patient has had a trial and inadequate response to intraarticular glucocorticoid injections and the preferred oral DMARD, methotrexate

□ Yes □ No There is evidence that the use of the preferred DMARD, methotrexate, is medically contraindicated
IF 'Yes', then DOCUMENTATION must be submitted which includes the following: documented evidence that the use of the DMARD, methotrexate, is medically contraindicated. Please Note: Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data

□ Yes □ No Patient has had a trial of leflunomide or sulfasalazine, instead of methotrexate

9. PHYSICIAN SIGNATURE

Prescriber or Authorized Signature _____ Date _____

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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