Cigna®

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Ilaris
(canakinumab)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Ilaris (canakinumab): ☐ Other (please specify):

Directions for use, dose and quantity:

Duration of therapy: J-Code: ICD10:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:

Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?

☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

What is the patient's diagnosis or reason for treatment?

☐ Cryopyrin-Associated Periodic Syndromes (CAPS). Note: This includes familial cold autoinflammatory syndrome (FCAS), Muckle-Wells syndrome (MWS), and neonatal onset multisystem inflammatory disease (NOMID) formerly known as chronic infantile neurological cutaneous and articular syndrome (CINCA).
☐ Familial Mediterranean Fever (FMF)
☐ Gout, Acute Flare
☐ Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD)
☐ Rheumatoid Arthritis (RA)
☐ Stills disease, adult onset (AOSD) - Please Note: If the patient is less than 18 years of age, select systemic juvenile idiopathic arthritis. Adult-onset Still's disease (AOSD) and systemic juvenile idiopathic arthritis (SJIA) are considered the same disease (Still's disease) but differ in age of onset.
☐ Systemic juvenile idiopathic arthritis (SJIA) - Please Note: If the patient 18 years of age or older, select Stills disease, adult onset (AOSD). Systemic juvenile idiopathic arthritis (SJIA) and adult-onset Still's disease (AOSD) are considered the same disease (Still's disease) but differ in age of onset.
☐ Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS)
☐ other (please specify):

(if none of the above) Please provide the patient's diagnosis or reason for treatment.

Clinical Information:

Will Ilaris be used in combination with another biologic agent for an inflammatory condition? Please note: examples include Adalimumab SC Products (Humira, biosimilars), Cimzia, Etanercept SC Products (Enbrel, biosimilars), Infliximab IV Products (Remicade, biosimilars), Zymfentra, Simponi SC, Simponi Aria, Tocilizumab Products (Actemra IV, biosimilar; Actemra SC, biosimilar), Kevzara, Orencia (SC or IV), Rituximab IV Products (Rituxan, biosimilars), Kineret, Omvoh, Ustekinumab products (Stelara [SC or IV]), Siliq, Cosentyx (SC or IV), Taltz, Bimzelx, Ilumya, Skyrizi (SC or IV), Tremfya (SC or IV), Entyvio (SC or IV). ☐ Yes ☐ No

If Cryopyrin-Associated Periodic Syndromes (CAPS). Note: This includes familial cold autoinflammatory syndrome (FCAS), Muckle-Wells syndrome (MWS), and neonatal onset multisystem inflammatory disease (NOMID) formerly known as chronic infantile neurological cutaneous and articular syndrome (CINCA).

What is the patient's body weight?
☐ 14 kg or less
☐ 15 kg to 40 kg
☐ over 40 kg

(If 14 kg or less) Please provide clinical support for requesting this DOSE for your patient (examples could include past doses tried, past medications tried, pertinent patient history).

(if 15 kg to 40 kg) Is the requested dosing up to 8 mg/kg per dose administered subcutaneously no more frequently than once every 4 weeks? ☐ Yes ☐ No

(if no) Please provide clinical support for requesting this DOSE for your patient (examples could include past doses tried, past medications tried, pertinent patient history).

(if over 40 kg) Is the requested dosing up to 600 mg per dose administered subcutaneously no more frequently than once every 4 weeks? ☐ Yes ☐ No

(if no) Please provide clinical support for requesting this DOSE for your patient (examples could include past doses tried, past medications tried, pertinent patient history).

Is the patient currently receiving Ilaris? ☐ Yes ☐ No

Has the patient already received at least 6 months of therapy with the requested medication? Please Note: Answer No if the patient has not received 6 months of therapy or if the patient is restarting therapy with this medication. ☐ Yes ☐ No

When assessed by at least one objective measure, has the patient experienced a beneficial clinical response from baseline (prior to initiating the requested medication)? Please Note: Examples of objective measures include resolution of fever, improvement in rash or skin manifestations, clinically significant improvement or normalization of serum markers (for example, C-reactive protein, amyloid A), reduction in proteinuria, and/or stabilization of serum creatinine. ☐ Yes ☐ No

Compared with baseline (prior to receiving the requested medication), has the patient experienced an improvement in at least one symptom? Note: Examples of improvement in symptoms include fewer cold-induced attacks; less joint pain/tenderness, stiffness, or swelling; decreased fatigue; improved function or activities of daily living. ☐ Yes ☐ No

Is Ilaris being prescribed by or in consultation with a rheumatologist, geneticist, allergist/immunologist, or dermatologist? ☐ Yes ☐ No

If Familial Mediterranean fever (FMF):

What is the patient's body weight?
☐ 40 kg or less
☐ over 40 kg

Is the requested dosing up to 4 mg/kg per dose administered subcutaneously no more frequently than once every 4 weeks? ☐ Yes ☐ No

(If no) Is the requested dosing up to 300 mg per dose administered subcutaneously no more frequently than once every 4 weeks? ☐ Yes ☐ No

(If No) Please provide clinical support for requesting this DOSE for your patient (examples could include past doses tried, past medications tried, pertinent patient history). ☐ Yes ☐ No

Is the patient currently receiving Ilaris? ☐ Yes ☐ No

Has the patient already received at least 6 months of therapy with the requested medication? Please Note: Answer No if the patient has not received 6 months of therapy or if the patient is restarting therapy with this medication. ☐ Yes ☐ No

When assessed by at least one objective measure, has the patient experienced a beneficial clinical response from baseline (prior to initiating the requested medication)? Please Note: Examples of objective measures include decreased frequency of attacks, resolution of fever, improvement in rash or skin manifestations, clinically significant improvement or normalization of serum markers (for example, C-reactive protein, amyloid A), reduction in proteinuria, and/or stabilization of serum creatinine. ☐ Yes ☐ No

Compared with baseline (prior to receiving the requested medication), has the patient experienced an improvement in at least one symptom? Note: Examples of improvement in symptoms include fewer cold-induced attacks; less joint pain/tenderness, stiffness, or swelling; decreased fatigue; improved function or activities of daily living. ☐ Yes ☐ No

Is Ilaris being prescribed by or in consultation with a rheumatologist, nephrologist, geneticist, gastroenterologist, oncologist, or hematologist? ☐ Yes ☐ No

Has the patient tried colchicine, unless contraindicated? ☐ Yes ☐ No

Will the patient be taking the medication in combination with colchicine, unless colchicine is contraindicated or not tolerated? ☐ Yes ☐ No

Does the patient have a C-reactive protein level that is 10 mg/L or greater OR elevated to at least two times the upper limit of normal for the reporting laboratory? ☐ Yes ☐ No

Does the patient have a history of at least one flare per month despite use of colchicine, OR was hospitalized for a severe flare? ☐ Yes ☐ No

If Hyperimmunoglobulin D syndrome (HIDS)/Mevalonate kinase deficiency (MKD):

What is the patient's body weight?
☐ 40 kg or less
☐ over 40 kg

(If 40 kg or less) Is the requested dosing up to 4 mg/kg per dose administered subcutaneously no more frequently than once every 4 weeks? ☐ Yes ☐ No

(if over 40 KgIs the requested dosing up to 300 mg per dose administered subcutaneously no more frequently than once every 4 weeks? ☐ Yes ☐ No

(If no) Please provide clinical support for requesting this DOSE for your patient (examples could include past doses tried, past medications tried, pertinent patient history).

Is the patient currently receiving Ilaris? ☐ Yes ☐ No

Has the patient already received at least 6 months of therapy with the requested medication? Please Note: Answer No if the patient has not received 6 months of therapy or if the patient is restarting therapy with this medication. ☐ Yes ☐ No

When assessed by at least one objective measure, has the patient experienced a beneficial clinical response from baseline (prior to initiating the requested medication)? Please Note: Examples of objective measures include decreased frequency of attacks, resolution of fever, improvement in rash or skin manifestations, clinically significant improvement or normalization of serum markers (for example, C-reactive protein, amyloid A), reduction in proteinuria, and/or stabilization of serum creatinine. ☐ Yes ☐ No

Compared with baseline (prior to receiving the requested medication), has the patient experienced an improvement in at least one symptom? Note: Examples of improvement in symptoms include fewer cold-induced attacks; less joint pain/tenderness, stiffness, or swelling; decreased fatigue; improved function or activities of daily living. ☐ Yes ☐ No

Is Ilaris being prescribed by or in consultation with a rheumatologist, nephrologist, geneticist, oncologist, or hematologist? ☐ Yes ☐ No

Does the patient have a C-reactive protein level that is 10 mg/L or greater OR elevated to at least two times the upper limit of normal for the reporting laboratory? ☐ Yes ☐ No

Does the patient have a history of at least three febrile acute flares within the previous 6-month period OR was hospitalized for a severe flare? ☐ Yes ☐ No

If Systemic juvenile idiopathic arthritis (SJIA):

Is the requested dosing up to 4 mg/kg to a maximum of 300 mg per dose administered subcutaneously no more frequently than once every 4 weeks? ☐ Yes ☐ No

(If no) Please provide clinical support for requesting this DOSE for your patient (examples could include past doses tried, past medications tried, pertinent patient history).

Is the patient currently receiving Ilaris? ☐ Yes ☐ No

Has the patient already received at least 6 months of therapy with the requested medication? Please Note: Answer No if the patient has not received 6 months of therapy or if the patient is restarting therapy with this medication. ☐ Yes ☐ No

When assessed by at least one objective measure, has the patient experienced a beneficial clinical response from baseline (prior to initiating the requested medication)? Please Note: Examples of objective measures include resolution of fever, improvement in rash or skin manifestations, clinically significant improvement or normalization of serum markers (e.g., C-reactive protein, erythrocyte sedimentation rate), and/or reduced dosage of corticosteroids. ☐ Yes ☐ No

Compared with baseline (prior to receiving the requested medication), has the patient experienced an improvement in at least one symptom? Note: Examples of improvement in symptoms include fewer cold-induced attacks; less joint pain/tenderness, stiffness, or swelling; decreased fatigue; improved function or activities of daily living. ☐ Yes ☐ No

Is the medication being prescribed by or in consultation with a rheumatologist? ☐ Yes ☐ No

If Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS):

What is the patient's body weight?
☐ 40 kg or less
☐ over 40 kg

(If yes) Is the requested dosing up to 4 mg/kg per dose administered subcutaneously no more frequently than once every 4 weeks? ☐ Yes ☐ No

(If no) Is the requested dosing up to 300 mg per dose administered subcutaneously no more frequently than once every 4 weeks? ☐ Yes ☐ No

(If no) Please provide clinical support for requesting this DOSE for your patient (examples could include past doses tried, past medications tried, pertinent patient history).

Is the patient currently receiving Ilaris? ☐ Yes ☐ No

Has the patient already received at least 6 months of therapy with the requested medication? Please Note: Answer No if the patient has not received 6 months of therapy or if the patient is restarting therapy with this medication. ☐ Yes ☐ No

When assessed by at least one objective measure, has the patient experienced a beneficial clinical response from baseline (prior to initiating the requested medication)? Please Note: Examples of objective measures include decreased frequency of attacks, resolution of fever, improvement in rash or skin manifestations, clinically significant improvement or normalization of serum markers (for example, C-reactive protein, amyloid A), reduction in proteinuria, and/or stabilization of serum creatinine. ☐ Yes ☐ No

Compared with baseline (prior to receiving the requested medication), has the patient experienced an improvement in at least one symptom? Note: Examples of improvement in symptoms include fewer cold-induced attacks; less joint pain/tenderness, stiffness, or swelling; decreased fatigue; improved function or activities of daily living. ☐ Yes ☐ No

Is Ilaris being prescribed by or in consultation with a rheumatologist, nephrologist, geneticist, oncologist, or hematologist? ☐ Yes ☐ No

Does the patient have a C-reactive protein level that is 10 mg/L or greater OR elevated to at least two times the upper limit of normal for the reporting laboratory? ☐ Yes ☐ No

Does the patient have a history of at least six flares per year OR was hospitalized for a severe flare? ☐ Yes ☐ No

If Stills Disease, Adult Onset (AOSD):

Is the requested dosing up to 4 mg/kg to a maximum of 300 mg per dose administered subcutaneously no more frequently than once every 4 weeks? ☐ Yes ☐ No

(If no) Please provide clinical support for requesting this DOSE for your patient (examples could include past doses tried, past medications tried, pertinent patient history).

Is the patient currently receiving Ilaris? ☐ Yes ☐ No

Has the patient already received at least 6 months of therapy with the requested medication? Please Note: Answer No if the patient has not received 6 months of therapy or if the patient is restarting therapy with this medication. ☐ Yes ☐ No

When assessed by at least one objective measure, has the patient experienced a beneficial clinical response from baseline (prior to initiating the requested medication)? Please Note: Examples of objective measures include resolution of fever, improvement in rash or skin manifestations, clinically significant improvement or normalization of serum markers (for example, C-reactive protein, erythrocyte sedimentation rate), and/or reduced dosage of corticosteroids. ☐ Yes ☐ No

Compared with baseline (prior to receiving the requested medication), has the patient experienced an improvement in at least one symptom? Note: Examples of improvement in symptoms include fewer cold-induced attacks; less joint pain/tenderness, stiffness, or swelling; decreased fatigue; improved function or activities of daily living. ☐ Yes ☐ No

Is Ilaris being prescribed by or in consultation with a rheumatologist? ☐ Yes ☐ No

If Gout, Acute Flare:

Does the patient have an intolerance, contraindication, or lack of response to nonsteroidal anti-inflammatory drugs (NSAIDs) for the treatment of acute gout flares? ☐ Yes ☐ No

Does the patient have an intolerance, contraindication, or lack of response to colchicine for the treatment of acute gout flares? ☐ Yes ☐ No

Has the patient previously been treated with corticosteroids (oral or injectable) for an acute gout flare? ☐ Yes ☐ No

According to the prescriber, is the patient unable to be retreated with a repeat course of corticosteroids (oral or injectable) for acute gout flare? ☐ Yes ☐ No

According to the prescriber, is the patient receiving or will the patient be taking concomitant urate lowering medication for the prevention of gout unless contraindicated? - Please Note: Examples of uric acid lowering drugs include allopurinol, febuxostat, or probenecid. ☐ Yes ☐ No

Is the medication being prescribed by or in consultation with a rheumatologist? ☐ Yes ☐ No

Is the requested dosing up to 150 mg administered subcutaneously no more frequently than once every 12 weeks? ☐ Yes ☐ No

(if no) Please provide clinical support for requesting this DOSE for your patient (examples could include past doses tried, past medications tried, pertinent patient history).

Additional Pertinent Information: (*Please provide any additional pertinent clinical information, including: if the patient is currently on the requested drug (with dates of use) and how they have been receiving it (for example: samples, out of pocket):*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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