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:

Patient's weight (in kg):

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)
☐ All other indications or diagnoses

Clinical Information:

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

For CAPS only:

Is the patient currently receiving Ilaris? ☐ Yes ☐ No

(if yes) Has the patient already received at least 6 months of therapy with the requested medication? Please Note: Answer No if the patient has received less than 6 months of therapy or who is restarting therapy with this medication. ☐ Yes ☐ No

(if yes) 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

(if 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

(if not currently receiving or received less than 6 mo) Is documentation being provided that the patient has a confirmed diagnosis of Cryopyrin-Associated Periodic Syndromes? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

(if not currently receiving or received less than 6 mo) Is the medication prescribed by or in consultation with a rheumatologist, geneticist, allergist/immunologist, or dermatologist? ☐ Yes ☐ No

For SJIA only:

Is the patient currently receiving Ilaris? ☐ Yes ☐ No

(if yes) Has the patient already received at least 6 months of therapy with the requested medication? Please Note: Answer No if the patient has received less than 6 months of therapy or who is restarting therapy with this medication. ☐ Yes ☐ No

(if yes) 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

(if 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

(if not currently receiving or received less than 6 mo) Is the medication prescribed by or in consultation with a rheumatologist? ☐ Yes ☐ No

For HIDS/MKD only:

Is the patient currently receiving Ilaris? ☐ Yes ☐ No

(if yes) Has the patient already received at least 6 months of therapy with the requested medication? Please Note: Answer No if the patient has received less than 6 months of therapy or who is restarting therapy with this medication. ☐ Yes ☐ No

(if not currently receiving or received less than 6 mo) Is the medication prescribed by or in consultation with a rheumatologist, nephrologist, geneticist, oncologist, or hematologist? ☐ Yes ☐ No

(if not currently receiving or received less than 6 mo) 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

(if not currently receiving or received less than 6 mo) 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 currently receiving Ilaris) 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

(if 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

For TRAPS only:

Is the patient currently receiving Ilaris? ☐ Yes ☐ No

(if yes) Has the patient already received at least 6 months of therapy with the requested medication? Please Note: Answer No if the patient has received less than 6 months of therapy or who is restarting therapy with this medication. ☐ Yes ☐ No

(if not currently receiving or received less than 6 mo) Is the medication prescribed by or in consultation with a rheumatologist, nephrologist, geneticist, oncologist, or hematologist? ☐ Yes ☐ No

(if not currently receiving or received less than 6 mo) 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

(if not currently receiving or received less than 6 mo) Does the patient have a history of at least six flares per year OR was hospitalized for a severe flare? ☐ Yes ☐ No

(if currently receiving Ilaris) 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

(if 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

For FMF only:

Is the patient currently receiving Ilaris? ☐ Yes ☐ No

(if yes) Has the patient already received at least 6 months of therapy with the requested medication? Please Note: Answer No if the patient has received less than 6 months of therapy or who is restarting therapy with this medication. ☐ Yes ☐ No

(if currently receiving) 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

(if 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

(if not currently receiving or received less than 6 mo) Is the medication prescribed by or in consultation with a rheumatologist, nephrologist, geneticist, gastroenterologist, oncologist, or hematologist? ☐ Yes ☐ No

(if not currently receiving or received less than 6 mo) Has the patient tried colchicine at the maximum tolerated dose? ☐ Yes ☐ No

(if yes) Will the patient be taking the requested medication in combination with colchicine? ☐ Yes ☐ No

(if not previously tried colchicine at max tolerated dose OR not taking in combination with colchicine) According to the prescriber, is colchicine contraindicated or not tolerated? ☐ Yes ☐ No

(if not currently receiving or received less than 6 mo) 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

(if not currently receiving or received less than 6 mo) 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

For Stills only:

Is the patient currently receiving Ilaris? ☐ Yes ☐ No

(if yes) Has the patient already received at least 6 months of therapy with the requested medication? Please Note: Answer No if the patient has received less than 6 months of therapy or who is restarting therapy with this medication. ☐ Yes ☐ No

(if currently receiving) 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

(if 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

if not currently receiving or receiving for less than 6 mo), Is the medication prescribed by or in consultation with a rheumatologist? ☐ Yes ☐ No

For Gout, Acute Flares only:

Does the patient have an intolerance, contraindication, or lack of response to nonsteroidal anti-inflammatory drugs (NSAIDs) for the treatment of acute gout flares?

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

(if no intolerance, contraindication or lack of response to NSAIDs or colchicine) Has the patient previously been treated with corticosteroids (oral or injectable) for an acute gout flare? ☐ Yes ☐ No

(if yes) 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 prescribed by or in consultation with a rheumatologist? ☐ Yes ☐ No

Additional Pertinent Information:

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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