



**Instructions:**

This form is used by Kaiser Permanente and/or participating providers for coverage of **Ilaris (canakinumab)**. Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: [1-866-331-2104](tel:1-866-331-2104)]. If you have any questions or concerns, please call [1-866-331-2103](tel:1-866-331-2103). **Requests will not be considered unless this form is complete.**

**KP-MAS Formulary can be found at:** [Pharmacy | Community Provider Portal | Kaiser Permanente](#)

**1 – Patient Information**

Patient Name: \_\_\_\_\_ Kaiser Medical ID#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**2 – Prescriber Information**

Is the prescriber a rheumatologist or gastroenterologist?  No  Yes

If consulted with a specialist, specialist name and specialty: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ NPI: \_\_\_\_\_

Prescriber Address: \_\_\_\_\_

Prescriber Phone #: \_\_\_\_\_ Prescriber Fax #: \_\_\_\_\_

**3 – Pharmacy Information**

Pharmacy Name: \_\_\_\_\_ Pharmacy NPI: \_\_\_\_\_

Pharmacy Phone #: \_\_\_\_\_ Pharmacy Fax #: \_\_\_\_\_

**4 – Drug Therapy Requested**

Drug 1: Name/Strength/Formulation: \_\_\_\_\_  
Sig: \_\_\_\_\_

Drug 2: Name/Strength/Formulation: \_\_\_\_\_  
Sig: \_\_\_\_\_

**5– Diagnosis/Clinical Criteria**

1. Is this request for initial or continuing therapy?  
 Initial therapy  Continuing therapy, state start date: \_\_\_\_\_
2. Indicate the patient’s diagnosis for the requested medication: \_\_\_\_\_

**Clinical Criteria:**

1. Member is  $\geq 2$  years old and has a diagnosis of systemic juvenile idiopathic arthritis  
 No  Yes
  
2. **AND** member has a documented inadequate response, contraindication, or inability to tolerate:
  - Actemra (tocilizumab), AND
  - Kineret (anakinra) No  Yes

**For continuation of therapy, please respond to additional question below:**

1. Is there a physician documentation of disease stability and improvement?  
 No  Yes

**7 – Prescriber Sign-Off**

**Additional Information –**

1. Please submit chart notes/medical records for the patient that are applicable to this request.
2. If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:

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**I certify that the information provided is accurate. Supporting documentation is available for State audits.**

<b>Prescriber Signature:</b>	<b>Date:</b>
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