Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Ilaris (canakinumabl) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorization: 12 months

Instructions:

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

Provider Name: _____ Specialty: _____ Provider NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

Please check the boxes that apply:

□ Initial Request □ Continuation of Therapy Request

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 the medication is being used for one of these indications?
   Periodic Fever Syndromes: □ Cryopyrin-Associated Periodic Syndromes (CAPS) □ Familial Cold Autoinflammatory Syndrome (FCAS) □Muckle-Wells Syndrome (MWS)

   □ Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS)

   □ Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD)

   □ Familial Mediterranean Fever (FMF)

   □ Active Still's Disease

   □ Systemic Juvenile Idiopathic Arthritis (SJIA)

   □ Gout Flares (NSAIDs and colchicine are contraindicated, are not tolerated, or do not provide an adequate response, and in whom repeated courses of corticosteroids are not appropriate)

2. Was there therapeutic failure on oral methotrexate? **AND**
   □ No □ Yes

3. Was there therapeutic failure to one of the preferred agents? **AND**
   □ No □ Yes

4. If this is being used for Systemic Juvenile Idiopathic Arthritis (SJIA) or Active Still Disease:
   a. Is the patient ≥2 years old?
      □ No □ Yes

6 – Provider 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:**

_____
_____
_____

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

Provider Signature:	**Date:**