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?

☐ COVID-19 (Coronavirus Disease 2019). Note: This includes requests for cytokine release syndrome associated with COVID-19
☐ 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
☐ Systemic Juvenile Idiopathic Arthritis (SJIA)
☐ 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:

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).

(if CAPS) Is this initial therapy or is the patient currently receiving Ilaris? If patient has been taking samples, please pick "initial therapy."

☐ Initial therapy or restarting therapy (if less than 6 months, choose this option)
☐ Currently receiving Ilaris for at least 6 months

(if CAPS initial) Is this medication being prescribed by, or in consultation with, a rheumatologist, geneticist, allergist/immunologist, or dermatologist? ☐ Yes ☐ No

(if CAPS 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 drug)? 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 initiating the requested drug), 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 no) Please provide support for continued use.

If Familial Mediterranean Fever (FMF)

(if FMF) Is this initial therapy or is the patient currently receiving Ilaris? If patient has been taking samples, please pick "initial therapy."

☐ Initial therapy or restarting therapy (if less than 6 months, choose this option)
☐ Currently receiving Ilaris for at least 6 months

(if FMF initial) Prior to starting Ilaris, is/was the patient's C-Reactive Protein (CRP) level greater than or equal to 10 mg/L? ☐ Yes ☐ No

(if no) Prior to starting Ilaris, is/was the patient's C-Reactive Protein (CRP) level elevated to at least two times the upper limit of normal for the reporting laboratory? ☐ Yes ☐ No

(if FMF initial) Is colchicine contraindicated in this patient? ☐ Yes ☐ No

(if FMF initial) Before starting Ilaris, did the patient have a trial of colchicine? ☐ Yes ☐ No

(if FMF initial) Will the patient take the requested medication in combination with colchicine? ☐ Yes ☐ No

(if FMF initial) Is the patient unable to tolerate colchicine? ☐ Yes ☐ No

(if FMF initial) Does the patient have a history of at least one flare per month despite use of colchicine? ☐ Yes ☐ No

(if no) Has the patient been hospitalized for a severe flare? ☐ Yes ☐ No

(if FMF initial) Is this medication being prescribed by, or in consultation with, a rheumatologist, nephrologist, geneticist, gastroenterologist, oncologist, or hematologist? ☐ Yes ☐ No

(if FMF 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 drug)? 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 initiating the requested drug), has the patient experienced an improvement in at least one symptom? Note: Examples of improvement in symptoms include decreased pain/tenderness, stiffness, or swelling; decreased fatigue; improved function or activities of daily living. ☐ Yes ☐ No

(if no) Please provide support for continued use.

If Gout, Acute Flare

(if gout) The covered alternatives are: nonsteroidal anti-inflammatory drugs (NSAIDs) and colchicine. For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced. For the alternatives NOT tried, please provide details why your patient can't try that drug.

(if gout) For nonsteroidal anti-inflammatory drugs (NSAIDs), per the information provided above, which of the following is true for your patient?

☐ The patient tried this alternative, but there was a lack of response.
☐ The patient tried this alternative, but they did not tolerate it.
☐ The patient cannot try this alternative because of a contraindication to this drug.
☐ Other

(if gout) For colchicine, per the information provided above, which of the following is true for your patient?

☐ The patient tried this alternative, but there was a lack of response.
☐ The patient tried this alternative, but they did not tolerate it.
☐ The patient cannot try this alternative because of a contraindication to this drug.
☐ Other

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

(if gout) Is the patient unable to be retreated with a repeat course of corticosteroids (oral or injectable) for acute gout flares? ☐ Yes ☐ No

(if gout) Is the patient receiving (or will be taking) concomitant urate lowering medication (for example, allopurinol, febuxostat, or probenecid) for the prevention of gout? ☐ Yes ☐ No

(if no) Is concomitant urate lowering medication (for example, allopurinol, febuxostat, or probenecid) for the prevention of gout contraindicated for this patient? ☐ Yes ☐ No

if Gout) Is the requested medication being prescribed by, or in consultation with, a rheumatologist? ☐ Yes ☐ No

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

(if HIDS/MKD) Is this initial therapy or is the patient currently receiving Ilaris? If patient has been taking samples, please pick "initial therapy."

☐ Initial therapy or restarting therapy (if less than 6 months, choose this option)
☐ Currently receiving Ilaris for at least 6 months

(if HIDS/MKD initial) Prior to starting Ilaris, is/was the patient's C-Reactive Protein (CRP) level greater than or equal to 10 mg/L? ☐ Yes ☐ No

(if no) Prior to starting Ilaris, is/was the patient's C-Reactive Protein (CRP) level elevated to at least two times the upper limit of normal for the reporting laboratory? ☐ Yes ☐ No

(if HIDS/MKD initial) Prior to starting Ilaris, does/did your patient have history of at least three febrile acute flares within the previous 6-month period? ☐ Yes ☐ No

(if no) Prior to starting Ilaris, is/was the patient hospitalized for a severe flare? ☐ Yes ☐ No

(if HIDS/MKD initial) Is the requested medication being prescribed by, or in consultation with, a rheumatologist, nephrologist, geneticist, oncologist, or hematologist? ☐ Yes ☐ No

(if HIDS/MKD 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 drug)? 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 initiating the requested drug), has the patient experienced an improvement in at least one symptom? Note: Examples of improvement in symptoms include decreased pain/tenderness, stiffness, or swelling; decreased fatigue; improved function or activities of daily living. ☐ Yes ☐ No

(if no) Please provide support for continued use.

If Stills Disease, Adult Onset

(if Still's Disease) Is this initial therapy or is the patient currently receiving Ilaris? If patient has been taking samples, please pick "initial therapy."

☐ Initial therapy or restarting therapy (if less than 6 months, choose this option)
☐ Currently receiving Ilaris for at least 6 months

Note: If the patient is less than 18 years of age, refer to criteria for systemic juvenile idiopathic arthritis.

(if Still's Disease initial) Was Ilaris started when the patient was in the hospital? ☐ Yes ☐ No

(if no) Has the patient tried at least one other biologic? Note: Examples of biologics for Still's disease include a tocilizumab product (Actemra intravenous infusion, biosimilar; Actemra subcutaneous injection), Kineret (anakinra subcutaneous injection). ☐ Yes ☐ No

(if Still's Disease initial) Is the requested medication being prescribed by, or in consultation with, a rheumatologist? ☐ Yes ☐ No

(if Still's Disease 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 drug)? 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 initiating the requested drug), has the patient experienced an improvement in at least one symptom? Note: Examples of improvement in symptoms include less joint pain/tenderness, stiffness, or swelling; decreased fatigue; improved function or activities of daily living. ☐ Yes ☐ No

(if no) Please provide support for continued use.

If Systemic Juvenile Idiopathic Arthritis (SJIA)

(if SJIA) Is this initial therapy or is the patient currently receiving Ilaris? If patient has been taking samples, please pick "initial therapy."

☐ Initial therapy or restarting therapy (if less than 6 months, choose this option)
☐ Currently receiving Ilaris for at least 6 months

(if SJIA initial) Was Ilaris started when the patient was in the hospital? ☐ Yes ☐ No

(if no) Has the patient tried at least one other biologic? Note: Examples of biologics for SJIA include a tocilizumab product (Actemra intravenous infusion, biosimilar; Actemra subcutaneous injection), Kineret (anakinra subcutaneous injection). ☐ Yes ☐ No

(if SJIA initial) Is the requested medication being prescribed by, or in consultation with, a rheumatologist? ☐ Yes ☐ No

(if SJIA 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 drug)? 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 initiating the requested drug), has the patient experienced an improvement in at least one symptom? Note: Examples of improvement in symptoms include less joint pain/tenderness, stiffness, or swelling; decreased fatigue; improved function or activities of daily living. ☐ Yes ☐ No

(if no) Please provide support for continued use.

If Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS)

(if TRAPS) Is this initial therapy or is the patient currently receiving Ilaris? If patient has been taking samples, please pick "initial therapy."

☐ Initial therapy or restarting therapy (if less than 6 months, choose this option)
☐ Currently receiving Ilaris for at least 6 months

(if TRAPS initial) Prior to starting Ilaris, is/was the patient's C-Reactive Protein (CRP) level greater than or equal to 10 mg/L? ☐ Yes ☐ No

(if no) Prior to starting Ilaris, is/was the patient's C-Reactive Protein (CRP) level elevated to at least two times the upper limit of normal for the reporting laboratory? ☐ Yes ☐ No

(if TRAPS initial) Prior to starting Ilaris, does/did your patient have history of at least six flares per year? ☐ Yes ☐ No

(if no) Has the patient been hospitalized for a severe flare? ☐ Yes ☐ No

(if TRAPS initial) Is the requested medication being prescribed by, or in consultation with, a rheumatologist, nephrologist, geneticist, oncologist, or hematologist? ☐ Yes ☐ No

(if TRAPS 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 drug)? 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 initiating the requested drug), has the patient experienced an improvement in at least one symptom? Note: Examples of improvements in symptoms include such as decreased pain/tenderness, stiffness, or swelling; decreased fatigue; improved function or activities of daily living. ☐ Yes ☐ No

(if no) Please provide support for continued use.

If Any Diagnosis:

Besides the drug being requested, other biologics include Actemra, adalimumab (Humira and all biosimilars), Adbry, Bimzelx, Cibinqo, Cimzia, Cosentyx, Enbrel, Entyvio, Ilumya, infliximab (Remicade and all biosimilars), Kevzara, Kineret, Litfulo, Olumiant, Omvoh, Orencia, Otezla, Rinvoq, rituximab (Rituxan and all biosimilars), Siliq, Simponi Aria, Simponi, Skyrizi, Sotyktu, Stelara, Taltz, Tremfya, Tysabri, Velsipity, Xeljanz, Zeposia. Which of the following best describes your patient's situation?

☐ The patient is NOT taking any other biological at this time, nor will they in the future. The requested drug is the only biological the patient is/will be using.
☐ The patient is currently on another biological, but this drug will be stopped and the requested drug will be started
☐ The patient is currently on another biological, and the requested drug will be added. The patient may continue to take both drugs together.
☐ The patient is currently on BOTH the requested drug AND another biological
☐ other/unknown

(If other/more than the requested drug) Please provide the rationale for concurrent use.

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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