

Pharmacy Prior Authorization Form

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

 This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Ilaris[®] (canakinumab)

 Urgent

 Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:

 Ilaris 180mg single use vial - 180 mg/6 mL

Dose: _____ Start date: _____

Place of administration:

 Provider's Office

 Outpatient Infusion Center

Name of center: _____

 Home Infusion

Name of agency: _____

Billing options:

 Physician buy and bill (J3590-unclassified biologic code until J code determined)

 Preferred Specialty Vendor

 Other: _____

Priority Health Precertification Requirements:

Authorization of Ilaris requires:

- One of the following diagnoses: Cryopyrin-Associated Periodic Syndromes (CAPS): including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS) in patients \geq 4 years old.

Please Complete the Following Information:

Diagnosis:

 Cryopyrin-Associated Periodic Syndromes (CAPS): including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS) –
ICD code: _____

Patient's age: _____

Patient's weight: _____

If approved, authorization for one injection (150mg for patients > 40kg and 2mg/kg for patients 15-40kg), every 8 weeks given by a health care professional, given indefinitely.

Note: Priority Health Medicare applies CMS local coverage determination criteria when available for Part B drugs. If no local coverage determination criteria is available for the state in which the member is receiving the services, the above prior authorization criteria must be met.

***** All fields must be complete and legible for Prior Authorization Review*****

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX