aetna®

Ilaris® (canakinumab) Injectable Medication Precertification Request

(All fields must be completed and legible for Precertification Review)

Aetna Precertification Notification
Phone: 1-855-240-0535
FAX: 1-877-269-9916

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy, Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:
Patient Current Weight: _____ lbs. or _____ kgs	Patient Height: _____ inches or _____ cms	Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check one):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ Rheumatologist ☐ **Other**:

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Ilaris: Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: ☐ _____ ☐ Other: _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For Initiation Requests: (Clinical documentation required for all requests)

☐ Yes ☐ No Will canakinumab (Ilaris) be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, infliximab)?
☐ Yes ☐ No Will the patient receive a live vaccine concurrently with canakinumab (Ilaris)?
☐ Yes ☐ No Has the patient been tested for TB with a PPD test, interferon-release assay (IGRA) or chest x-ray within 6 months of initiating a biologic therapy?
→ (check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray
Please enter the date and results of the TB test: Date: ____/____/____ Results: ☐ Positive ☐ Negative ☐ Unknown
If positive, does the patient have latent or active TB? ☐ Latent ☐ Active
If latent TB, ☐ Yes ☐ No Will TB treatment be started before initiation of therapy with canakinumab (Ilaris)?

Cryopyrin-Associated Periodic Syndromes (CAPS)

☐ Yes ☐ No Does the patient have familial cold auto-inflammatory syndrome (FCAS) with classic signs and symptoms (recurrent, intermittent fever and rash that were often exacerbated by exposure to generalized cool ambient temperature)?
☐ Yes ☐ No Does the patient have Muckle-Wells syndrome (MWS) with classic signs and symptoms (chronic fever and rash of waxing and waning intensity, sometimes exacerbated by exposure to generalized cool ambient temperature)?
☐ Yes ☐ No Is there clinical documentation of functional impairment resulting in limitations of activities of daily living?

Systemic Juvenile Idiopathic Arthritis (SJIA)

☐ Yes ☐ No Is there evidence the disease is active?
☐ Yes ☐ No Does the patient's initial symptoms include high fevers and painful polyarthritis (severe disease)?
☐ Yes ☐ No Has the patient had an ineffective response to non-steroidal anti-inflammatory drug (NSAID) monotherapy treatment?
→ Please provide the name and date range of the NSAID that was tried:
Name: _____ Date range: ____/____/____ to ____/____/____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION (*continued*) Required clinical information must be completed in its entirety for all precertification requests.

Familial Mediterranean Fever (FMF)

How many flares per month does the patient have? _____

Please indicate the C-reactive protein level: Level: _____ mg/L Date: ____/____/____

☐ Yes ☐ No Was treatment with colchicine ineffective?
Please provide date range: ____/____/____ to ____/____/____

☐ Yes ☐ No Was the trial with colchicine not tolerated?

☐ Yes ☐ No Is colchicine contraindicated?

Hyperimmonoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD)

☐ Yes ☐ No Has the diagnosis been confirmed by mevalonate kinase (MVK) gene/enzymatic (MKD) findings?
→ Please provide the date of the testing: ____/____/____

☐ Yes ☐ No Does the patient have a documented prior history of febrile acute flares?

☐ Yes ☐ No Is there documentation of greater than 3 febrile acute flares within a 6 month period when not receiving prophylactic treatment?

☐ Yes ☐ No Does the patient have active HIDS flares?
→ Please indicate the Physician Global Assessment (PGA) score: _____
Please provide the C-reactive protein level and date obtained: Level: _____ mg/L Date: ____/____/____

Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS)

☐ Yes ☐ No Does the patient have chronic or recurrent disease activity? ☐ chronic ☐ recurrent
→ Please indicate how many flares per year that patient has had: _____
Please indicate the Physician Global Assessment (PGA) score: _____
Please provide the C-reactive protein level and date obtained: Level: _____ mg/L Date: ____/____/____

For Continuation Requests: (Clinical documentation required for all requests)

☐ Yes ☐ No Will canakinumab (Ilaris) be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, infliximab)?

☐ Yes ☐ No Has the patient received samples of canakinumab (Ilaris)? (Sampling of Ilaris does not guarantee coverage under the provisions of the pharmacy benefit)

☐ Yes ☐ No Will the patient receive a live vaccine concurrently with canakinumab (Ilaris)?

☐ Yes ☐ No Is there clinical documentation of disease stability or improvement? ☐ Disease stability ☐ Improvement

☐ Yes ☐ No Does the patient have any risk factors for TB?
→ ☐ Yes ☐ No Has the patient had a TB test (PPD test, IGRA, or chest x-ray) within the past year?
(check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray
Please enter the date and results of the TB test: Date: ____/____/____
Results: ☐ Positive ☐ Negative ☐ Unknown

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.