Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Immunomodulators: Ilaris

Member Information

1. Member Last Name: _____ 2. First Name: _____
3. Member ID #: _____4. Member Date of Birth: _____ 5. Member Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name:_____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days ☐ Other _____

Clinical Information

Request for Systemic Onset Juvenile Idiopathic Arthritis (SJIA)

1. Does the member have a diagnosis of Systemic Juvenile Idiopathic Arthritis? ☐ **Yes** ☐ **No**
2. Is the member not on another injectable biologic immunomodulator? ☐ **Yes** ☐ **No**
3. Has the member been considered and screened for the presence of latent tuberculosis infection? ☐ **Yes** ☐ **No**
4. Has the member been tested with Hep B SAG and Core Ab? ☐ **Yes** ☐ **No**
5. Has the member experienced inadequate symptom relief from treatment with at least two NSAIDS? ☐ **Yes** ☐ **No**
6. Does the member have systemic arthritis with active systemic features and features of poor prognosis, as determined by the prescribing physician (e.g. arthritis of the hip, radiographic damage)? ☐ **Yes** ☐ **No**

Request for Cryopyrin-Associated Periodic Syndromes (CAPS) including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS)

1. Does the member have a diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS) including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS)? ☐ **Yes** ☐ **No**
2. Is the member not on another injectable biologic immunomodulator? ☐ **Yes** ☐ **No**
3. Has the member been considered and screened for the presence of latent tuberculosis infection? ☐ **Yes** ☐ **No**
4. Has the member been tested with Hep B SAG and Core Ab? ☐ **Yes** ☐ **No**

Request for Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS)

1. Does the member have a diagnosis of Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS)? ☐ **Yes** ☐ **No**
2. Is the member not on another injectable biologic immunomodulator? ☐ **Yes** ☐ **No**
3. Has the member been considered and screened for the presence of latent tuberculosis infection? ☐ **Yes** ☐ **No**
4. Has the member been tested with Hep B SAG and Core Ab (not required for Otezla)? ☐ **Yes** ☐ **No**

Request for Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD)

1. Does the member have a diagnosis of Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD)? ☐ **Yes** ☐ **No**
2. Is the member not on another injectable biologic immunomodulator? ☐ **Yes** ☐ **No**
3. Has the member been considered and screened for the presence of latent tuberculosis infection (not required for Otezla)? ☐ **Yes** ☐ **No**
4. Has the member been tested with Hep B SAG and Core Ab (not required for Otezla)? ☐ **Yes** ☐ **No**

Request for Familial Mediterranean Fever (FMF)

1. Does the member have a diagnosis of Familial Mediterranean Fever (FMF)? ☐ **Yes** ☐ **No**
2. Is the member not on another injectable biologic immunomodulator? ☐ **Yes** ☐ **No**
3. Has the member been considered and screened for the presence of latent tuberculosis? ☐ **Yes** ☐ **No**
6. Has the member been tested with Hep B SAG and Core Ab? ☐ **Yes** ☐ **No**

Request for Adult Onset Still's Disease

1. Does the member have a diagnosis of Adult Onset Still's Disease? ☐ **Yes** ☐ **No**
2. Is the member not on another injectable biologic immunomodulator? ☐ **Yes** ☐ **No**
3. Has the member been considered and screened for the presence of latent tuberculosis? ☐ **Yes** ☐ **No**
4. Has the member been tested with Hep B SAG and Core Ab? ☐ **Yes** ☐ **No**
5. Does the member have has systemic arthritis with active systemic features and features of poor prognosis, as determined by the prescribing physician (e.g. arthritis of the hip, radiographic damage) ? ☐ **Yes** ☐ **No**

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.