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:

Is this a new start or continuation of therapy? ☐ new start ☐ continued therapy
(if continued therapy) Has therapy with Ilaris resulted in clinical demonstration of disease stability or improvement in this patient? ☐ Yes ☐ No
Will your patient be using Ilaris in combination with any other biologic agent (for example: Actemra, Cimzia, Enbrel, Entyvio, Humira, Inflectra, Kineret, Orencia, Otezla, Remicade, Rituxan, Simponi [Aria], Stelara, Taltz, Xeljanz [XR])? ☐ Yes ☐ No

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 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):

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

Diagnosis related to use:

☐ familial cold autoinflammatory syndrome (FCAS)
☐ familial Mediterranean fever (FMF)
☐ hyperimmunoglobulin D [Hyper-IgD] syndrome (HIDS) / mevalonate kinase deficiency (MKD)
☐ Muckle-Wells syndrome
☐ Still's disease
☐ systemic juvenile idiopathic arthritis (sJIA)
☐ tumor necrosis factor [TNF] receptor associated periodic syndrome (TRAPS)
☐ other (please specify):

Clinical Information:

(if FMF) Has your patient tried colchicine therapy? ☐ Yes ☐ No

(if yes) Does your patient experience at least 1 flare per month despite colchicine therapy OR does your patient have a documented intolerance to effective doses of colchicine? ☐ Yes ☐ No

(if HIDS/MKD) Does your patient have a history of 3 or more febrile acute flares within a 6 month period? ☐ Yes ☐ No

(if Stills) Did your patient try one corticosteroid (for example, prednisone) for at least 2 months, but it either did not work well enough OR caused a significant intolerance? ☐ Yes ☐ No

(if no) Is your patient able to try the alternative, one corticosteroid? ☐ Yes ☐ No

(if no) What is the reason your patient can not try the alternative, one corticosteroid?

☐ Patient has at least one contraindication or warning as listed in the alternative drug's prescribing information.

☐ Patient is not a candidate for the alternative due to a disease characteristic, individual clinical factor[s], or other attribute/condition.

☐ other

Please provide specifics to support this reason. ____________

(if Stills) Did your patient try one conventional synthetic disease-modifying antirheumatic drug (DMARD) (for example, methotrexate), but it either did not work well enough OR caused a significant intolerance? ☐ Yes ☐ No

(if no) Is your patient able to try the alternative, one DMARD? ☐ Yes ☐ No

(if no) What is the reason your patient can not try the alternative, one DMARD?

☐ Patient has at least one contraindication or warning as listed in the alternative drug's prescribing information.

☐ Patient is not a candidate for the alternative due to a disease characteristic, individual clinical factor[s], or other attribute/condition.

☐ other

Please provide specifics to support this reason. ____________

(if Still's) Is this drug being prescribed by, or in consultation with, a rheumatologist or a prescriber who specializes in Still's Disease? ☐ Yes ☐ No

(if TRAPS) Does your patient have 6 or more flares per year? ☐ Yes ☐ No

(if FMF, HIDS/MKD, or TRAPS) Is your patient's C-Reactive Protein (CRP) level greater than 10 mg/L? ☐ Yes ☐ No

Additional Pertinent Information: (*including names of any alternatives tried, including date(s) taken and for how long, and what the documented results were of taking the drug, including any intolerances or adverse reactions your patient experienced):*

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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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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