

# IL-1 INHIBITORS

## PRIOR AUTHORIZATION REQUEST

### PRESCRIBER FAX FORM

**Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.**

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit [www.myprime.com](http://www.myprime.com). Start saving time today by filling out this form electronically. Visit [covermy meds.com](http://covermy meds.com) to begin using this free service.

**What is the priority level of this request?**

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

**Today’s Date:** \_\_\_\_\_

**PATIENT AND INSURANCE INFORMATION**

**Date of Service (if differs from Today’s Date):** \_\_\_\_\_

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

**PRESCRIBER/CLINIC INFORMATION**

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

**PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST**

Patient’s Diagnosis: <input type="checkbox"/> Cryopyrin-Associated Periodic Syndrome (CAPS) <input type="checkbox"/> Recurrent pericarditis <input type="checkbox"/> Deficiency of interleukin-1 receptor antagonist (DIRA) <input type="checkbox"/> Other (ICD code plus description): _____
Medication Requested: _____      Strength: _____
Dosing Schedule: _____      Quantity per Month: _____
<b>For all requests:</b> 1. What is the patient’s weight? _____ (kg) 2. Is the patient currently treated with the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Does the patient have any FDA labeled contraindications to the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify FDA labeled contraindication: _____ _____ 4. Is the patient’s age within FDA labeling for the requested indication for the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please provide support for using the requested agent for the patient’s age for the requested indication: _____ _____ _____ 5. Is the prescriber a specialist in the area of the patient’s diagnosis (e.g., allergist, cardiologist, immunologist, pediatrician, rheumatologist), or has the prescriber consulted with a specialist in the area of the patient’s diagnosis? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Please list all reasons for selecting the requested agent, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). <b>Please note, documentation may be required:</b> _____ _____ _____ _____
<b>Please continue to the next page.</b>

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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7. Will the patient be using the requested agent in combination with another immunomodulatory agent (e.g., TNF inhibitors, JAK inhibitors, IL-4 inhibitors) [Abrilada, Actemra, Adalimumab, Adbry, Amjevita, Arcalyst, Avsola, Avtozma, Benlysta, Bimzelx, Cibinqo, Cimzia, Cinqair, Cosentyx, Cyltezo, Dupixent, Ebglyss, Enbrel, Entyvio, Fasenra, Hadlima, Hulio, Humira, Hyrimoz, Idacio, Ilaris, Ilumya, Imuldosa, Inflectra, Infiximab, Kevzara, Kineret, Leqselvi, Litfulo, Nemluvio, Nucala, Olumiant, Omlyclo, Omvoh, Opzelura, Orenzia, Otezla, Otulfi, Pyzchiva, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Rituxan Hycela, Ruxience, Saphnelo, Selarsdi, Siliq, Simlandi, Simponi, Simponi ARIA, Skyrizi, Sotyktu, Spevigo subcutaneous injection, Stelara, Steqeyma, Taltz, Tezspire, Tofidence, Tremfya, Truxima, Tyenne, Tysabri, Ustekinumab, Velsipity, Wezlana, Xeljanz, Xeljanz XR, Xolair, Yesintek, Yuflyma, Yusimry, Zeposia, Zymfentra]?.....  Yes  No

If yes, does the prescribing information for the requested agent limit the use with another immunomodulatory agent? .....  Yes  No

If no, is there support for the use of combination therapy? Please note, a submitted copy of clinical trials, phase III studies, or guidelines is required. ....  Yes  No

**If yes, please submit supporting copy of clinical trials, phase III studies, and/or guidelines.**

**For Cryopyrin-Associated Periodic Syndrome (CAPS) requests:**

8. Does the patient have ONE of the following disorders (phenotypes)?.....  Yes  No

If yes, please select ALL that apply:

- Familial Cold Autoinflammatory Syndrome (FCAS)
- Muckle-Wells Syndrome (MWS)

9. Does the patient have a history of elevated pretreatment serum inflammatory markers (C-reactive protein/serum amyloid A)? .....  Yes  No

10. Does the patient have a history of at least TWO symptoms typical for cryopyrin-associated periodic syndrome (CAPS) (i.e., urticaria-like rash, cold/stress triggered episodes, sensorineural hearing loss, musculoskeletal symptoms of arthralgia/arthritis/myalgia, chronic aseptic meningitis, skeletal abnormalities of epiphyseal overgrowth/frontal bossing)?.....  Yes  No

**For Deficiency of interleukin-1 receptor antagonist (DIRA) requests:**

11. Was the patient's diagnosis confirmed via genetic testing for mutations in the IL1RN gene?.....  Yes  No

12. Is the requested agent being used for maintenance of remission?.....  Yes  No

**For Recurrent pericarditis (RP) requests:**

13. Does the patient have pericarditis that recurs after a symptom-free interval of 4 weeks or longer after an (initial) acute pericarditis episode? .....  Yes  No

14. Has the patient tried and had an inadequate response to colchicine after at least a 6-month duration of therapy?...  Yes  No

If no, does the patient have an intolerance or hypersensitivity to colchicine? .....  Yes  No

If yes, please explain intolerance/hypersensitivity: \_\_\_\_\_

If no, does the patient have an FDA labeled contraindication to colchicine? .....  Yes  No

If yes, please specify FDA labeled contraindication: \_\_\_\_\_

15. Was colchicine used concomitantly with a non-steroidal anti-inflammatory drug (NSAID) used in the treatment of RP for at least a 1-week duration of therapy? .....  Yes  No

If no, was colchicine used concomitantly with aspirin used in the treatment of RP for at least a 1-week duration of therapy? .....  Yes  No

If no, does the patient have an intolerance or hypersensitivity to ONE NSAID OR aspirin used in the treatment of RP? .....  Yes  No

If yes, please explain intolerance/hypersensitivity: \_\_\_\_\_

If no, does the patient have an FDA labeled contraindication to ALL NSAIDs AND aspirin used in the treatment of RP? .....  Yes  No

If yes, please specify FDA labeled contraindication: \_\_\_\_\_

**Please continue to the next page.**

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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16. Was colchicine used concomitantly with a corticosteroid used in the treatment of RP for at least a 1-week duration of therapy? .....  Yes  No

If no, does the patient have an intolerance or hypersensitivity to ONE corticosteroid used in the treatment of RP? .....  Yes  No

If yes, please explain intolerance/hypersensitivity: \_\_\_\_\_

If no, does the patient have an FDA labeled contraindication to ALL corticosteroids used in the treatment of RP? .....  Yes  No

If yes, please specify FDA labeled contraindication: \_\_\_\_\_

**For renewal requests:**

17. Has the patient had clinical benefit with the requested agent? .....  Yes  No

**Please fax or mail this form to:**  
 Prime Therapeutics LLC  
 Clinical Review Department  
 2900 Ames Crossing Road Suite 200  
 Eagan, MN 55121

**TOLL FREE**

**Phone:**  
**BCBSIL: 800.285.9426**  
**BCBSMT: 888.723.7443**  
**BCBSNM: 800.544.1378**  
**BCBSOK: 800.991.5643**  
**BCBSTX: 800.289.1525**

**Fax: 877.243.6930**

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