# AvMed

## MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

**Directions:** **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-877-535-1391**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

**For Medicare Members:** Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

# SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (sJIA) OR ADULT ONSET STILL'S DISEASE (AOSD)

**Drug Requested: Ilaris®** (canakinumab) **(J0638) (Medical) (Non-Preferred)**

## Medication can ONLY be provided by a Physician's office

**MEMBER & PRESCRIBER INFORMATION:** Authorization may be delayed if incomplete.

**Member Name:** _____

**Member AvMed #:** _____ **Date of Birth:** _____

**Prescriber Name:** _____

**Prescriber Signature:** _____ **Date:** _____

**Office Contact Name:** _____

**Phone Number:** _____ **Fax Number:** _____

**NPI #:** _____

**DRUG INFORMATION:** Authorization may be delayed if incomplete.

**Drug Name/Form/Strength:** _____

**Dosing Schedule**: _____ **Length of Therapy**: _____

**Diagnosis:** _____ **ICD Code, if applicable:** _____

**Weight (if applicable):** _____ **Date weight obtained:** _____

**Recommended dosage: every 4 weeks SQ: 4mg/kg (with a maximum of 300mg) > 7.5kg**

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

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**CLINICAL CRITERIA:** Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

**Initial approval - 3 months.** For **continued 12-month approval**, please refax form with documentation of CRP or ESR along with progress notes to document therapy effective.

## ❑ DIAGNOSIS: Systemic Juvenile Idiopathic Arthritis (sJIA)

- ❑ Members must be aged 2 years - 17years

**AND**

- ❑ Member must have had persistent sJIA activity for a minimum of six (6) months
  - Date of diagnosis must be noted _____

**AND**

- ❑ Member must have trial and failure of NSAIDs and corticosteroids for > 3 months consecutively within the last 4 months **(paid claims will be reviewed for verification)**

**AND**

- ❑ Member must have had ≥ 5 active joints with concomitant fever for at least 2 weeks within the last 3 months of this request

**OR**

- ❑ Member must have had > 2 active joints with concomitant fever for at least 5 days and trial of prednisone or equivalent dosed at 0.5mg/kg/day or 30mg/day within the last 3 months of this request

**AND**

- ❑ Member must have had CRP (>15 mg/L) within the last 2 months of this year

**AND**

- ❑ Member must have had ESR (>45mm/hr) within the last 2 months of this year

**AND**

- ❑ Member must have had fever > 38o C or 100.4o F for at least 2 weeks within the last 2 months of this request

**AND**

- ❑ Member must have documented failure of Kineret® & either Arcalyst® or Actemra® **(failure is defined as paid claims of Kineret® & Actemra® for at least 6 months AND lab values above did not respond to the preferred drug)**

**OR**

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- ❑ Member has history of anaphylactic reaction to Kineret®, Arcalyst® or Actemra® **[anaphylaxis is defined as an emergency department (ER/ED) visit due to throat or tongue swelling and/or shortness of breath]** or development of skin reactions that lead to Stevens Johnson syndrome.

## ❑ DIAGNOSIS: Adult Onset Still's Disease (AOSD)

- ❑ Members must be aged ≥ 18 years and ≤ 75 years

**AND**

- ❑ Member must meet two of the following:
  - ❑ Fever >39 °C, lasting 1 week or longer
  - ❑ Arthralgia or arthritis, lasting 2 weeks or longer
  - ❑ Typical rash
  - ❑ Leukocytosis >10,000/mm3 with >80% polymorphonuclear cells

**AND**

- ❑ Disease activity based on DAS28 of ≥3.2 at screening

**AND**

- ❑ Member must have had CRP (>15 mg/L) within the last 2 months of this year

**AND**

- ❑ Member must have had ESR (>45mm/hr) within the last 2 months of this year

**AND**

- ❑ At least 4 painful and 4 swollen joints at least 2 weeks within the last 3 months of this request

**AND**

- ❑ Trial and failure with glucocorticoids, stable dose of ≤10 mg/day (prednisolone or equivalent) for at least 4 weeks AND NSAIDs, at least 4 weeks **(at least 2 weeks within the last 3 months of this request)**

**AND**

- ❑ Trial and failure Kineret® and either Arcalyst® or Actemra® **(progress notes must be submitted for true failure)**

**Reauthorization Approval: 1 year.** Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied. Check box below for the Diagnosis that applies.

## For sJIA:

- ❑ Documentation decrease ESR <30.mg/L AND ESR<13mm/h

**AND**

**(Continued on next page)**

- ❑ Numbered of swollen joints have decreased

## For AOSD:

- ❑ Documentation decrease ESR <30.mg/L AND ESR<13mm/h

**AND**

- ❑ Numbered of swollen joints have decreased

**AND**

- ❑ DAS28 have decreased <2.6

**Progress notes and labs documenting anaphylactic reaction or development of SJS must be submitted**.

## Medication being provided by a Specialty Pharmacy - PropriumRx

For urgent reviews: Practitioner should call AvMed Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. AvMed's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

***Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

**Previous therapies will be verified through pharmacy paid claims or submitted chart notes.***



***Approved by Pharmacy and Therapeutics Committee**: 6/21/2018
**REVISED/UPDATED:** ~~9/29/2018; (Reformatted) 3/16/2019; 7/7/2019; 9/22/2019; 10/7/2019; 11/12/2020;~~ **10/11/2021**