UnitedHealthcare Community Plan

Ilaris – Nebraska
PRIOR AUTHORIZATION REQUEST FORM

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form contains multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information:		

Is the requested medication □ New or □ Continuation of Therapy? If continuation, list start date: _____
Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Physician Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs
Please refer to www.uhccommunityplan.com for a list of preferred alternatives

UnitedHealthcare Community Plan

Ilaris – Nebraska
PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

	ALL REQUESTS
□ **Yes** □ **No**	**Does the patient have one of the following diagnoses?** *(If yes, check which applies)* □ Familial Cold Autoinflammatory Syndrome (FCAS) □ Muckle-Wells Syndrome (MWS) □ Tumor Necrosis Factor (TNF) Receptor associated Periodic Syndrome (TRAPS) □ Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD) □ Familial Mediterranean Fever (FMF) □ Active Systemic Juvenile idiopathic arthritis (SJIA)
	FAMILIAL MEDITERRANEAN FEVER (FMF)
□ **Yes** □ **No**	**Does the patient have a history of failure, contraindication, or intolerance to colchicine?** *(If yes, complete Section D above)*
	SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA)
□ **Yes** □ **No**	**Is the patient receiving Ilaris in combination with another biologic agent (e.g. Actemra)?**
□ **Yes** □ **No**	**Is the provider a rheumatologist or immunologist with expertise in the patient's diagnosis?**
□ **Yes** □ **No**	**Has there been consultation with a rheumatologist or immunologist with expertise in the patient's diagnosis?**
	CONTINUATION OF THERAPY
□ **Yes** □ **No**	**Is there documentation of positive clinical response to Ilaris therapy?** *If yes, list response:*
□ **Yes** □ **No**	**Is the patient receiving Ilaris therapy in combination with another biologic agent (e.g. Actemra)?**

Physician Signature: _____ **Date:** _____