

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 <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____ Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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**

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

Physician Signature: _____ **Date:** _____

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