

CRITERIA FOR PRIOR AUTHORIZATION

Ilaris® (canakinumab)

PROVIDER GROUP Pharmacy
Professional

MANUAL GUIDELINES The following drug requires prior authorization:
Canakinumab (Ilaris®)

CRITERIA FOR CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES (CAPS) (must meet all of the following):

- Patient must have a diagnosis of CAPS, including:
 - Familial Cold Autoinflammatory Syndrome (FCAS)
 - Muckle-Wells Syndrome (MWS)
- Patient must be 4 years of age or older
- Patient must have an evaluation for latent tuberculosis (TB) with a TB skin test prior to initial prior authorization approval
- Patient must not be taking another IL-1 blocking agent or biologic agent (see attached table) within the past 30 days

CRITERIA FOR JUVENILE IDIOPATHIC ARTHRITIS (JIA) (must meet all of the following):

- Patient must have a diagnosis of active, systemic juvenile idiopathic arthritis
- Must be prescribed by or in consultation with a rheumatologist or dermatologist
- Patient must have an evaluation for latent TB with a TB skin test prior to initial prior authorization approval
- Patient must be 2 years of age or older
- Patient must not be taking another IL-1 blocking agent or biologic agent (see attached table) within the past 30 days

CRITERIA FOR TUMOR NECROSIS FACTOR RECEPTOR ASSOCIATED PERIODIC SYNDROME (TRAPS) (must meet all of the following):

- Patient must have a diagnosis of tumor necrosis factor receptor associated periodic syndrome
- Patient must have an evaluation for latent TB with a TB skin test prior to initial prior authorization approval
- Patient must not be taking another IL-1 blocking agent or biologic agent (see attached table) within the past 30 days

PA Criteria

CRITERIA FOR HYPERIMMUNOGLOBULIN D SYNDROME (HIDS)/MEVALONATE KINASE DEFICIENCY (MKD) (must meet all of the following):

- Patient must have a diagnosis of hyperimmunoglobulin D syndrome/mevalonate kinase deficiency
- Patient must have an evaluation for latent TB with a TB skin test prior to initial prior authorization approval
- Patient must not be taking another IL-1 blocking agent or biologic agent (see attached table) within the past 30 days

CRITERIA FOR FAMILIAL MEDITERRANEAN FEVER (FMF) (must meet all of the following):

- Patient must have a diagnosis of active, systemic juvenile idiopathic arthritis
- Must be prescribed by or in consultation with a rheumatologist or dermatologist
- Patient must have an evaluation for latent TB with a TB skin test prior to initial prior authorization approval
- Patient must not be taking another IL-1 blocking agent or biologic agent (see attached table) within the past 30 days

LENGTH OF APPROVAL 12 months

DRUG UTILIZATION REVIEW COMMITTEE CHAIR

PHARMACY PROGRAM MANAGER
DIVISION OF HEALTH CARE FINANCE
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

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DATE

IL-1 Blocking & Biologic Agents	
Generic Name	Brand Name
Abatacept	Orencia®
Etanercept	Enbrel®, Erelzi®
Alefacept	Amevive®
Anakinra	Kineret®
Certolizumab	Cimzia®
Golimumab	Simponi®
Infliximab	Remicade®, Inflectra®
Natalizumab	Tysabri®
Rituximab	Rituxan®
Tocilizumab	Actemra®
Ustekinumab	Stelara®
Secukinumab	Cosentyx®
Vedolizumab	Entyvio®
Adalimumab	Humira®, Amjevita®
Rilonacept	Arcalyst®
Tofacitinib	Xeljanz®

Revision History	
Revision Date	Revision
January 11, 2017	Add criteria for new indications of TRAPS, HIDS/MKD, and FMF
April 13, 2016	Changed approval duration to 12 months from 6 months
July 10, 2013	Add criteria for new indication, juvenile idiopathic arthritis; remove quantity limit of 1 vial every 8 weeks (JIA approved dose is higher than limit)
October 21, 2009	Initial prior authorization criteria approved