



**Immunomodulators: Adult Onset Still's Disease  
(Ilaris)**

**Beneficiary Information**

1. Beneficiary Last Name: \_\_\_\_\_ 2. First Name: \_\_\_\_\_  
3. Beneficiary ID #: \_\_\_\_\_ 4. Beneficiary Date of Birth: \_\_\_\_\_ 5. Beneficiary Gender: \_\_\_\_\_

**Prescriber Information**

6. Prescribing Provider NPI #: \_\_\_\_\_  
7. Requester Contact Information –  
Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Ext. \_\_\_\_\_

**Drug Information**

8. Drug Name: \_\_\_\_\_ 9. Strength: \_\_\_\_\_ 10. Quantity Per 30 Days: \_\_\_\_\_  
11. Length of Therapy (in days):  up to 30 Days  60 Days  90 Days  120 Days  180 Days  
 365 Days  Other \_\_\_\_\_

**Clinical Information**

- 1. Does the beneficiary have a diagnosis of Adult Onset Still's Disease?  **Yes**  **No**
- 2. Is the beneficiary on any other injectable immunomodulator?  **Yes**  **No**
- 3. Has the beneficiary been screened for latent tuberculosis infection?  **Yes**  **No**
- 4. Has the beneficiary been tested with Hep B SAG and Core Ab?  **Yes**  **No**
- 5. Does the beneficiary have systemic arthritis with active systemic features and features of poor prognosis, as determined by the prescribing physician (e.g. arthritis of the hip, radiographic damage)?  **Yes**  **No**

Signature of Prescriber: \_\_\_\_\_ Date: \_\_\_\_\_

**(Prescriber Signature Mandatory)**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to **1-800-678-3189** Pharmacy PA Call Center: **1-866-799-5318**