

**Pharmacy Request for Prior Approval – Hyperimmunoglobulin D Syndrome  
(HIDS) / Mevalonate Kinase Deficiency (MKD)  
(Ilaris)**

**Beneficiary Information**

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

**Prescriber Information**

6. Prescriber Name: \_\_\_\_\_ NPI #: \_\_\_\_\_  
Mailing address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
7. Requester Contact Information: \_\_\_\_\_  
Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**Drug Information**

8. Drug Name: \_\_\_\_\_ 9. Strength: \_\_\_\_\_ 10. Quantity Per 30 Days: \_\_\_\_\_  
11. Length of Therapy: \_\_\_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 Hyperimmunoglobulin D Syndrome (HIDS)/ Mevalonate Kinase Deficiency (MKD)?  
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\_\_\_

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.