KAISER PERMANENTE®

206-988-2000
206-988-2001
prnotification@kp.org

Kaiser Foundation Health Plan of Washington
Kaiser Foundation Health Plan of Washington Options, Inc.
Provider Communications, RCR-A3W-04
PO Box 34262, Seattle WA 98124-1262

August 17, 2026

CANAKINUMAB (ILARIS) NOT COVERED UNDER THE MEDICAL BENEFIT

Dear Provider,

Canakinumab (Ilaris) is on the **non-Medicare** list of office-administered drugs requiring prior authorization. **Effective November 1, 2026,** Canakinumab (Ilaris) will **NOT** be covered under the medical benefit. Pharmacy benefit coverage remains available for members who meet prior authorization criteria. This change does not affect current authorizations for canakinumab (Ilaris). However, any new authorizations are subject to the criteria below. **This letter is a notification of the upcoming change in prior authorization criteria required before administering this medication under the medical benefit.**

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington, Options, Inc. (Kaiser Permanente) require prior authorization for a select group of injectable drugs that may be administered under the medical benefit in a physician's office or by home infusion. These reviews are intended to ensure consistent benefit adjudication as well as appropriate utilization in accordance with the Kaiser Permanente Pharmacy & Therapeutics Committee's evidence-based criteria for coverage.

BRAND NAME	GENERIC NAME	HCPCS
Ilaris	**Canakinumab**	**J0638**

Prior Authorization Criteria for Canakinumab (Ilaris) (changes in bold):

DRUG NAME	COVERAGE CRITERIA
Canakinumab (Ilaris)	**Considered a self-administered medication for outpatient use. Not covered under the medical benefit (hospital, clinic, or home infusion). May be covered under the pharmacy benefit. Exceptions to self-administration may be considered based on the following:** • **First dose for new starts to allow for self-administration training OR** • **Documentation of impaired manual dexterity, impaired vision, or inability to safely self-administer AND** • **Must meet clinical criteria (refer to pharmacy benefit*)** **Note: Must be administered in a non-hospital setting. See site of care policy for criteria, reauthorization, and exceptions for new starts.** *Pharmacy benefit criteria: • Covered for patients 2 years or older with systemic juvenile idiopathic arthritis (sJIA) with active systemic features who have failure, contraindication, or intolerance to NSAIDs, glucocorticoids, anakinra, AND tocilizumab. ○ Note: Active systemic features include fever, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly, or serositis.

DRUG NAME	COVERAGE CRITERIA
	• Covered for patients 4 years or older with a diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS) with familial cold auto-inflammatory syndrome (FCAS) or Muckle-Wells syndrome (MWS) who have a confirmed NLRP3 (or CIAS1) mutation. • Medical necessity review required for other indications Quantity Limits: • CAPS diagnosis: 150 mg every 8 weeks • All other diagnoses: 300 mg every 4 weeks

Additional Information
A complete list of office-administered injectable drugs requiring prior authorization can be found on the Kaiser Permanente provider website at https://wa-provider.kaiserpermanente.org/provider-manual/clinical-review/officeinject.

To request prior authorization review, please use the Referral Request online form (login required) located on the Kaiser Permanente provider website. You can also fax your request to the Review Services department toll-free at 1-888-282-2685.

Thank you for the care you provide for our members, your patients. If you have any questions about this process, please call Review Services at 1-800-289-1363, Monday through Friday, from 8:00 a.m. to 5:00 p.m.

Sincerely,

Ravi Ubriani, MD, Chair
Pharmacy & Therapeutics Committee