carolina complete health

Immunomodulators Temporary PA Request Form

ANKYLOSING SPONDYLITIS
(Enbrel, Humira, Cosentyx, Inflectra, Cimzia, Simponi, Simponi Aria, Remicade, Renflexis)

Beneficiary Information

1. Beneficiary Last Name:_____2. First Name:_____

3. Beneficiary ID #:_____4. Beneficiary Date of Birth:_____5. Recipient Gender:_____

Prescriber Information

6. Prescribing Provider NPI#:_____

7. Requester Contact Information - Name:_____Phone #:_____Ext:_____

Drug Information

8. Med requested:_____9a.Strength_____9b. Quantity per 30 days_____9c. Length of therapy_____

10. Does the beneficiary have a diagnosis of Ankylosing Spondylitis? **YES**____**NO**____

11. Is the beneficiary on any other injectable immunomodulator? **YES**____**NO**____

12. Has the beneficiary been screened for latent tuberculosis infection? **YES**____**NO**____

13. Has the beneficiary been tested with Hep B SAG and Core Ab? **YES**____**NO**____
Date of lab and result_____

14. Has the beneficiary experienced inadequate symptom relief from treatment with at least 2 NSAIDs?
YES____**NO**____**List NSAIDS used**_____

15. Is the beneficiary unable to use NSAIDs? **YES**_____**NO**_____**Explain**_____

16. Does the beneficiary have clinical evidence of severe or rapidly progressing disease? **YES**____**NO**____
Explain_____

17. If requesting a non-preferred, list preferred tried or reason beneficiary cannot use **one** preferred.
_____
_____

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: (877) 386-4695 Pharmacy PA Call Center: (833) 585-4309