carolina complete health

Immunomodulators Temporary PA Request Form

Hidradenitis Suppurativa (Humira)

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 Hidradenitis Suppurativa? **YES**___ **NO**____

11. Is the beneficiary age 12 or older? **YES**___ **NO**____

12. Is the beneficiary on any other injectable immunomodulator? **YES**___ **NO**___

13. Has the beneficiary been screened for latent tuberculosis infection? **YES**___ **NO**___

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

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