carolina complete health

Immunomodulators Temporary PA Request Form

Polyarticular Juvenile Idiopathic Arthritis (Enbrel, Humira, Actemra SQ, Actemra Infusion, Orencia Infusion and Orencia SQ)

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 Polyarticular Juvenile Idiopathic Arthritis? **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 tried one systemic corticosteroid (e.g. prednisone, methylprednisolone) or methotrexate, leflunomide or sulfasalazine with inadequate response or is unable to take these therapies due to contraindications? **YES**___ **NO**___

List meds tried or reason beneficiary cannot use corticosteroid, methotrexate, leflumomide or sulfasalazine._____

_____

15. Does the beneficiary have PJIA subtype enthesitis related arthritis? **YES**___ **NO**___

16. 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