carolina complete health

Immunomodulators Temporary PA Request Form

Psoriatic Arthritis (Enbrel, Humira, Inflectra, Cosentyx, Cimzia, Orencia, Orencia Infusion, Otezla, Renflexis, Remicade, Simponi, Simponia Aria, Stelara, Taltz, Xeljanz and Xeljanz XR)

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 Psoriatic 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 experienced a therapeutic failure/inadequate response with methotrexate?

YES___ **NO**____

15. Is the beneficiary unable to take methotrexate due to contraindications or intolerabilities?

YES___ **NO**____ **Explain**_____

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