Immunomodulators Temporary PA Request Form

Crohn's Disease (Pediatric)
(Humira, Inflectra, 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 moderate to severe Crohn's disease? **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. 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