carolina complete health

Immunomodulators Temporary PA Request Form

Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS) (Ilaris)

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 Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS)? **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____

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