carolina complete health

Immunomodulator Temporary PA Request Form

Ulcerative Colitis (Adult) (Avsola, Humira, Entyvio, Inflectra, Remicade, Renflexis, Simponi, Stelara, Xeljanz, and Xeljanz XR)

Beneficiary Information

1. Beneficiary Last Name:________________________________ 2. First Name:______________

3. Beneficiary ID #:___________4. Beneficiary Date of Birth:__________ 5. Beneficiary Gender:________

Prescriber Information

6. Prescribing Provider NPI#:________________

7. Requester Contact Information - Name:__________________ Phone #: ___________Ext:__________

Drug Information

8. Medication Requested: ________________________________

9a. Strength_______9b. Quantity per 30 days_____9c. Duration____

10. Does the member have a diagnosis of Ulcerative Colitis? **YES**___ **NO**____

11. Is the member's age 18 or above? **YES**___ **NO**____

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

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

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

15. If requesting a non-preferred, list preferred tried or reason member cannot use the 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 for to: (833) 404-2393 Pharmacy PA Call Center: (833) 585-4309

https://www.covermymeds.com/main/prior-authorization-forms/