carolina complete health

Immunomodulators Temporary PA Request Form

Crohn's Disease (Adult)
(Humira, Avsola, Cimzia, Entyvio, Inflectra, Stelara, Remicade, Renflexis)

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. Length of Therapy: _____

10. Does the member have moderate to severe Crohn's disease? **YES**_____**NO**____

11. Is the member age 18 or greater? **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 **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.