carolina complete health

Immunomodulators Temporary PA Request Form

Cytokine Release Syndrome (Actemra and Actemra SQ)

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. Med requested:_____9a.Strength____9b. Quantity per 30 days_____9c. Length of therapy____

10. Does the member have a diagnosis of Giant Cell Arteritis? **YES**_____**NO**_____

11. Is the member on any other injectable immunomodulator? **YES**_____**NO**_____

12. Has the member 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: (833) 404-2393 Pharmacy PA Call Center: (833) 585-4309

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