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