carolina complete health

Immunomodulators Temporary PA Request Form

Non-Infectious Intermediate Posterior Panuveitis (Humira)

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: _____

8. Phone #: _____Ext: _____

Drug Information

9. Med requested: _____9a. Strength____9b. Quantity per 30 days___9c. Length of Therapy____

10. Does the member have a diagnosis of Non-Infectious Intermediate Posterior Panuveitis?

YES___ NO____

11. Is the member's age 2 or older? **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_____

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.