carolina complete health

Polyarticular Juvenile Idiopathic Arthritis (Enbrel, Humira, Actemra SQ, Actemra Infusion, Simponi Aria, Xeljanz, Orencia Infusion and Orencia 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. Duration____

10. Does the member have Polyarticular Juvenile Idiopathic Arthritis? **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_____

14. Has the member tried one systemic corticosteroid (e.g. prednisone, methylprednisolone) or methotrexate, leflunomide or sulfasalazine with inadequate response or is unable to take these therapies due to contraindications?
YES___ **NO**___

List meds tried or reason member cannot use corticosteroid, methotrexate, leflunomide or sulfasalazine. _____

15. Does the member have PJIA subtype enthesitis related arthritis? **YES**___ **NO**___

16. If requesting a non-preferred, list preferred tried or reason beneficiary 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.