carolina complete health

Psoriatic Arthritis (Avsola, Enbrel, Humira, Inflectra, Cosentyx, Cimzia, Orencia, Orencia Infusion, Otezla, Renflexis, Remicade, Simponi, Simponia Aria, Stelara, Taltz, Tremfya, Xeljanz and Xeljanz XR)

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 a diagnosis of Psoriatic Arthritis? **YES**___ **NO**____11. Is the member age 18 or older; for Simponi Aria age 2 years 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_____

15. Has the member experienced a therapeutic failure/inadequate response with methotrexate?

YES___ **NO**____

16. Is the member unable to take methotrexate due to contraindications or intolerabilities?

YES___ **NO**____ **Explain**_____

17. 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.