carolina complete health

Immunomodulators Temporary PA Request Form

Behcet's Disease (Otezla)

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. Medication requested: ________________

9. 9a. Strength: ____ 9b. Quantity per 30 days: ___ 9c. Length of Therapy: _______

10. Does the beneficiary have a diagnosis of oral ulcers associated with Behcet's Disease? **YES___NO___**

11. Is the beneficiary's age 18 or older? **YES_____NO___**

12. Is the beneficiary on any other injectable immunomodulator? **YES___ NO___**

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/