carolina complete health

Rheumatoid Arthritis (Enbrel, Humira, Actemra Infusion, Actemra SQ, Cimzia, Inflectra, Kevzara, Kineret, Olumiant, Orencia Infusion, Orencia SQ, Remicade, Renflexis, Rinvoq ER, Simponi, Simponi Aria, 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. Medication requested: _____________9a.Strength_______9b. Quantity per 30 days_____9c. Duration____

10. Does the member have a diagnosis of Rheumatoid 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 experienced a therapeutic failure/inadequate response with methotrexate or at least one disease modifying anti-rheumatic drug (e.g. leflunomide, hydroxychloroquine, minocycline, sulfasalazine)?
YES___ **NO**____

15. Is the member unable to take methotrexate or at least one disease modifying anti-rheumatic drug due to contraindications or intolerabilities?
YES___ **NO**____ **Explain**____

16. Does the member have clinical evidence of severe or rapidly progressing disease? **YES**___ **NO**____

17. If requesting a non-preferred, list preferred tried or reason member 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.

Fax this form to: (833) 404-2393 Pharmacy PA Call Center: (833) 585-4309

https://www.covermymeds.com/main/prior-authorization-forms/