carolina complete health

Immunomodulators Temporary PA Request Form

Adult Onset Still's Disease

(Ilaris)

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. Drug Name: __________________________ 9. Strength: ______________ 10. Quantity Per 30 Days: 28 _____
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days ☐ Other _____

Clinical Information

1. Does the member have a diagnosis of Adult Onset Still's Disease? ☐ **Yes** ☐ **No**
2. Is the member on any other injectable immunomodulator? ☐ **Yes** ☐ **No**
3. Has the member been screened for latent tuberculosis infection? ☐ **Yes** ☐ **No**
4. Has the member been tested with Hep B SAG and Core Ab? ☐ **Yes** ☐ **No**
5. Does the member have systemic arthritis with active systemic features and features of poor prognosis, as determined by the prescribing physician (e.g. arthritis of the hip, radiographic damage)? ☐ **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/