NC Medicaid and NC Health Choice Pharmacy Prior Approval Request for Immunomodulators: Familial Mediterranean Fever (FMF) (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:_____
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 beneficiary have a diagnosis of Familial Mediterranean Fever (FMF)? ☐ **Yes** ☐ **No**
2. Is the beneficiary on any other injectable immunomodulator? ☐ **Yes** ☐ **No**
3. Has the beneficiary been screened for latent tuberculosis infection? ☐ **Yes** ☐ **No**
4. Has the beneficiary been tested with Hep B SAG and Core Ab? ☐ **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 **1-800-678-3189** Pharmacy PA Call Center: **1-866-799-5318**

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