



**NC Medicaid and NC Health Choice Pharmacy Prior Approval Request for Immunomodulators: Oral
Ulcers Associated with 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. 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. Is the beneficiary age 18 or older? **Yes** **No**
- 2. Does the beneficiary have a documented diagnosis of Behcet's disease? **Yes** **No**
- 3. 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 **1-800-678-3189** Pharmacy PA Call Center: **1-866-799-5318**