NC Medicaid and NC Health Choice Pharmacy Prior Approval Request for Immunomodulators: Ankylosing Spondylitis (Enbrel, Humira, Cosentyx, Avsola, Inflectra, Cimzia, Simponi, Simponi Aria, Remicade, Renflexis and Taltz)

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 ankylosing spondylitis? ☐ **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**
5. Has the beneficiary experienced inadequate symptom relief from treatment with at least 2 NSAIDs? ☐ **Yes** ☐ **No**
   Please list NSAIDs used: ____
6. Is the beneficiary unable to use NSAIDs? ☐ **Yes** ☐ **No** **Please Explain:**
   ____
   ____
7. Does the beneficiary have clinical evidence of severe or rapidly progressing disease? ☐ **Yes** ☐ **No**
   Please Explain: ____
8. Has the beneficiary tried and failed Cosentyx, Enbrel or Humira? ☐ **Yes** ☐ **No**
   8a. If No, please provide the clinical reason why the beneficiary has not tried Cosentyx, Enbrel or Humira:
   ____
   ____
   ____

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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