



**NC Medicaid and NC Health Choice Pharmacy Prior Approval Request for Immunomodulators:
Ulcerative Colitis – Pediatric (Avsola and Remicade)**

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 17 or younger? Yes No
- 2. Does the beneficiary have a diagnosis of ulcerative colitis? Yes No
- 3. Is the beneficiary on any other injectable immunomodulator? Yes No
- 4. Has the beneficiary been screened for latent tuberculosis infection? Yes No
- 5. 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**