



NC Medicaid and NC Health Choice Pharmacy Prior Approval Request for Immunomodulators: Non-Radiographic Axial Spondyloarthritis (Cimzia, Cosentyx, 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 Non-Radiographic Axial Spondyloarthritis? **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 failed an adequate trial of a Non-Steroidal Anti-Inflammatory Drug (NSAID)?
 Yes **No** 5a. If no, please list contraindications that the beneficiary has to trial of NSAIDs:

6. **For use of a non-preferred medication:** Has the beneficiary tried and failed Cosentyx? **Yes** **No**
6a. If No, please provide the clinical reason why the beneficiary has not tried Cosentyx:

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**