WellCare
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NC Medicaid and NC Health Choice Pharmacy Prior Approval Request for Immunomodulators: Psoriatic Arthritis

(Enbrel, Humira, Cosentyx, Avsola, Cimzia, Inflectra, Orencia SQ, Orencia Infusion, Otezla, Remicade,Renflexis, Simponi, Simponi Aria, Stelara, Taltz, Tremfya, Xeljanz and Xeljanz XR)

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. For Simponi Aria: is the beneficary age 2 or older? ☐**Yes** ☐ **No**
3. Does the beneficiary have a definitive diagnosis of psoriatic arthritis? ☐ **Yes** ☐ **No**
4. Is the beneficiary on any other injectable immunomodulator? ☐ **Yes** ☐ **No**
5. Has the beneficiary been screened for latent tuberculosis infection? ☐ **Yes** ☐ **No**
6. Has the beneficiary been tested with Hep B SAG and Core Ab? ☐**Yes** ☐ **No**
7. Does the beneficiary have a documented inadequate response or inability to take methotrexate? ☐**Yes** ☐ **No**
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 thatany falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to **(800) 678-3189** Pharmacy PA Call Center: **(866) 799-5318**