WellCare
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NC Medicaid and NC Health Choice Pharmacy Prior Approval Request for Immunomodulators: Ulcerative Colitis – Adults (Humira, Avsola, Entyvio, Inflectra, Remicade, Renflexis, Stelara, Simponi, 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. 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**
6. Has the beneficiary tried and failed Humira? ☐**Yes** ☐ **No**

6a. If no, please provide the clinical reason why the beneficiary has not tried 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**