AmeriHealth Caritas North Carolina

# Pharmacy Request for Prior Approval – Crohn's Disease (Adult)

**(Avsola, Cimzia, Entyvio, Humira, Inflectra, Remicade, Renflexis, Stelara, and Stelara Infusion)**

**Beneficiary Information**

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

**Prescriber Information**

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

**Drug Information**

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: __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 moderate to severe Crohn's Disease? Yes___ No___
2. Is the beneficiary 18 years of age or older? 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 that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

**Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406**