AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Rheumatoid Arthritis

(Actemra Infusion, Actemra SQ, Avsola, Cimzia, Enbrel, Humira, Inflectra, Kevzara, Kineret, Olumiant, Orencia Infusion, Orencia SQ, Remicade, Renflexis, Rinvoq ER, Simponi, Simponi Aria, 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. 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 definitive diagnosis of rheumatoid arthritis? 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. Does the beneficiary have a documented inadequate response with methotrexate or at least one disease modifying antirheumatic drug (e.g. leflunomide, hydroxychloroquine, minocycline, sulfasalazine)? Yes___ No___
6. Is the beneficiary unable to receive methotrexate or disease modifying antirheumatic drugs due to contraindications or intolerabilities? Yes___ No___
7. Does the beneficiary have clinical evidence of severe or rapidly progressing disease? Yes___ No___
8. Has the beneficiary tried and failed Enbrel or Humira? Yes___ No___
   8a. If no, please provide the clinical reason why the beneficiary has not tried 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 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