NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
Immunomodulators: Ankylosing Spondylitis

(Enbrel, Humira, Cosentyx, Avsola, Inflectra, Cimzia, Simponi, Simponi Aria, Remicade, Renflexis 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 Ankylosing Spondylitis? ☐ **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 experienced inadequate symptom relief from treatment with at least 2 NSAIDs? ☐ **Yes** ☐ **No**
   Please List NSAIDS used: _____
6. Is the beneficiary unable to use NSAIDs? ☐ **Yes** ☐ **No** **Please Explain:** _____
   _____
7. Does the beneficiary have clinical evidence of severe or rapidly progressing disease? ☐ **Yes** ☐ **No**
   Please Explain: _____
8. Has the beneficiary tried and failed Cosentyx, Enbrel or Humira? ☐ **Yes** ☐ **No**
   8b. 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 that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.