NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
Immunomodulators: Polyarticular Juvenile Idiopathic Arthritis (PJIA)

(Enbrel, Humira, Actemra SQ, Actemra Infusion, Simponi Aria, Orencia SQ, Orencia Infusion, and Xeljanz)

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 Polyarticular Juvenile Idiopathic 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. Has the beneficiary tried any of the following with inadequate response:
   - ☐ Systemic corticosteroid or methotrexate
   - ☐ Leflunomide or sulfasalazine
   - ☐ Unable to take them due to contraindications
6. Does the beneficiary have PJIA subtype enthesitis related arthritis? ☐ **Yes** ☐ **No**
7. Has the beneficiary tried and failed Enbrel or Humira? ☐ **Yes** ☐ **No**
   7a. 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 CSRA at (855) 710-1969 Pharmacy PA Call Center: (866) 246-8505