NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
Immunomodulators: Rheumatoid Arthritis

(Enbrel, Humira, Actemra Infusion, Actemra SQ, Avsola, Cimzia, Inflectra, Kevzara, Kineret, Olumiant, Orencia, 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. 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 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 CSRA at (855) 710-1969 Pharmacy PA Call Center: (866) 246-8505