

**NC 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. 6. Has the beneficiary tried and failed Cosentyx, Enbrel or Humira? Yes No
6a. 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.