AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Olumiant

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. Dose: _____ 10. Directions: _____
11. Length of Therapy: __up to 30 days __60 days __90 days __120 days __180 days __365 days __Other: _____

Clinical Information

Request for Rheumatoid Arthritis:

1. Does the beneficiary have a diagnosis of Rheumatoid Arthritis? Yes___ No___
2. Is the beneficiary on another injectable biologic immunomodulator? Yes___ No___
3. Has the beneficiary's individual risks and benefits been considered prior to initiating or continuing therapy in those at higher risk for malignancy and/or major adverse cardiovascular events (MACE)? Yes___ No___
4. Is the beneficiary considered to be at high risk for thrombosis? Yes___ No___
5. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes___ No___
6. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes___ No___
7. Will the beneficiary receive live vaccines during therapy? Yes___ No___
8. Has the beneficiary experienced a therapeutic failure/inadequate response with at least one Tumor Necrosis Factor Blocker? Yes___ No___
9. Is the beneficiary unable to receive Tumor Necrosis Factor Blockers due to contraindications or intolerabilities? Yes___ No___
10. Has the beneficiary had a trial and failure of Enbrel or Humira or a clinical reason beneficiary cannot try Enbrel or Humira? Yes___ No___

Request for FDA Approved Diagnosis Not Listed Above:

1. Diagnosis: _____
2. Is the beneficiary on another injectable biologic immunomodulator? Yes___ No___
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes___ No___
4. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes___ No___

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