NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

WellCare
Beyond Healthcare. A Better You.

# Crohn's Disease - (Cimzia and Humira)

**Beneficiary Information**
1. Beneficiary Last Name:____________________________ 2. First Name:__________________

3. Beneficiary ID #:_________4. Beneficiary Date of Birth:________ 5. Recipient Gender:_______

**Prescriber Information**
6. Prescribing Provider NPI#:_____________

7. Requester Contact Information - Name:______________ Phone #: __________Ext:_________

**Drug Information**
8. Med requested: ______________9a.Strength_______9b. Quantity per 30 days_____9c. Duration____

10. Does the beneficiary have moderate to severe Crohn's disease? **YES**___ **NO**___

11. Is the beneficiary on any other injectable immunomodulator? **YES**___ **NO**___

12. Has the beneficiary been screened for latent tuberculosis infection? **YES**___ **NO**___

13. Has the beneficiary been tested with Hep B SAG and Core Ab? **YES**__ **NO**___ Date of lab and result__________________________________________________

14. If requesting a non-preferred, list preferred tried or reason beneficiary cannot use **one** preferred. (Humira is preferred.)
_____________________________________________________________________________________
_____________________________________________________________________________________

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: **(800) 678-3189** Pharmacy PA Call Center: **(866) 799-5318**