NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

WellCare
Beyond Healthcare. A Better You.

Psoriatic Arthritis - (Enbrel, Humira, and Simponi)

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 a diagnosis of Psoriatic Arthritis? **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. Has the beneficiary experienced a therapeutic failure/inadequate response with methotrexate? **YES**___ **NO**____
15. Is the beneficiary unable to take methotrexate due to contraindications or intolerabilities? **YES**___ **NO**____

Explain_____

16. Does the beneficiary have clinical evidence of severe or rapidly progressing disease? **YES**___ **NO**____
17. If requesting a non-preferred, list preferred tried or reason beneficiary cannot use the 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**