ANKYLOSING SPONDYLITIS
(Enbrel, Humira, Simponi, and Cimzia)

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 Ankylosing Spondylitis? **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: ____

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14. Has the beneficiary experienced inadequate symptom relief from treatment with at least 2 NSAIDs?
YES___ **NO**___ List **NSAIDS used**: ____
15. Is the beneficiary unable to use NSAIDs? **YES**____ **NO**_______ **Explain:** ______________________

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16. Does the beneficiary have clinical evidence of severe or rapidly progressing disease? **YES**___ **NO**___
Explain: ____

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17. If requesting a non-preferred, list preferred tried or reason beneficiary cannot use **one** preferred. (Enbrel and Humira are the preferred drugs)

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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**