North Carolina Department of Health and Human Services
NC Medicaid and NC Health Choice
Immunomodulators Temporary PA Request Form

Crohn’s Disease (Adult)
(Humira, Cimzia, Entyvio, Inflectra, Stelara, Stelara Infusion, Remicade, Renflexis)

Beneficiary Information
1. Beneficiary Last Name: __________________________ 2. First Name: __________

Prescriber Information
6. Prescribing Provider NPI#: ______________________
7. Requester Contact Information - Name: ____________ Phone #: __________ Ext: __________

Drug Information
10. Does the beneficiary have moderate to severe Crohn’s disease? YES___ NO___
11. Is the beneficiary age 18 or greater? YES___ NO___
12. Is the beneficiary on any other injectable immunomodulator? YES___ NO___
13. Has the beneficiary been screened for latent tuberculosis infection? YES___ NO___
14. Has the beneficiary been tested with Hep B SAG and Core Ab? YES___ NO___
   Date of lab and result ____________________________________________
15. If requesting a non-preferred, list preferred tried or reason beneficiary cannot use one 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 NCTracks at: (855) 710-1969 Pharmacy PA Call Center: (866) 246-8505

DMA-3555