North Carolina Department of Health and Human Services  
Division of Medical Assistance  
Immunomodulators Temporary PA Request Form  

**Systemic Onset Juvenile Idiopathic Arthritis  
(For Kineret, Ilaris, and Actrema SQ)**

**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 has a diagnosis of juvenile idiopathic arthritis? YES ___  
    NO ___

11. Does the beneficiary have systemic arthritis with active systemic features and features of poor prognosis (e.g. arthritis of the hip, radiographic damage)? 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 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 CSRA at: (855) 710-1969 Pharmacy PA Call Center: (866) 246-8505

DMA-3564