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

**Crohn’s Disease (Pediatric)**
*(Humira, Inflectra, Remicade, Renflexis)*

**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. Length of therapy____
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.
   __________________________________________________________________
   __________________________________________________________________

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

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