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

Systemic Onset Juvenile Idiopathic Arthritis (For Actemra SQ, Actemra Infusion and Ilaris)

**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 has a diagnosis of Systemic Onset Juvenile Idiopathic 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. 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___
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

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