UnitedHealthcare Community Plan

NC Pharmacy Prior Approval Request for
Immunomodulators: Psoriatic Arthritis

(Enbrel, Humira, Cosentyx, Avsola, Cimzia, Inflectra, Orencia SQ, Orencia Infusion, Otezla, Remicade, Renflexis, Simponi, Simponi Aria, Stelara, Taltz, Tremfya, Xeljanz and Xeljanz XR)

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: ____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days:_____
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days ☐ Other _____

Clinical Information

1. Is the beneficiary age 18 or older? ☐ **Yes** ☐ **No**
2. For Simponi Aria: is the beneificary age 2 or older? ☐ **Yes** ☐ **No**
3. Does the beneficiary have a definitive diagnosis of psoriatic arthritis? ☐ **Yes** ☐ **No**
4. Is the beneficiary on any other injectable immunomodulator? ☐ **Yes** ☐ **No**
5. Has the beneficiary been screened for latent tuberculosis infection? ☐ **Yes** ☐ **No**
6. Has the beneficiary been tested with Hep B SAG and Core Ab? ☐ **Yes** ☐ **No**
7. Does the beneficiary have a documented inadequate response or inability to take methotrexate? ☐ **Yes** ☐ **No**
8. Has the beneficiary tried and failed Cosentyx, Enbrel, or Humira? ☐ **Yes** ☐ **No**
   8a. If no, please provide the clinical reason why the beneficiary has not tried Cosentyx, Enbrel, or Humira:
   _____

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 1-866-940-7328 Pharmacy PA Call Center: 1-855-258-1593