UnitedHealthcare Community Plan

NC Pharmacy Prior Approval Request for
Immunomodulators: Non-Radiographic Axial Spondyloarthritis

(Cimzia, Cosentyx, and Taltz)

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. Does the beneficiary have a diagnosis of Non-Radiographic Axial Spondyloarthritis? ☐ **Yes** ☐ **No**
2. Is the beneficiary on any other injectable immunomodulator? ☐ **Yes** ☐ **No**
3. Has the beneficiary been screened for latent tuberculosis infection? ☐ **Yes** ☐ **No**
4. Has the beneficiary been tested with Hep B SAG and Core Ab? ☐ **Yes** ☐ **No**
5. Has the beneficiary failed an adequate trial of a Non-Steroidal Anti-Inflammatory Drug (NSAID)? ☐ **Yes** ☐ **No**
   5a. If no, please list contraindications that the beneficiary has to trial of NSAIDs: _____
   _____
6. For use of a non-preferred medication; has the beneficiary tried and failed Cosentyx? ☐ **Yes** ☐ **No**
   6a. If No, Please provide the clinical reason why the beneficiary has not tried Cosentyx: _____
   _____

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