NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

WellCare
Beyond Healthcare. A Better You.

Juvenile Idiopathic Arthritis - (Actemra SQ, Enbrel, Humira, and Orencia 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 have Juvenile Idiopathic Arthritis? **YES**___ **NO**___

11. Does the beneficiary have JIA subtype enthesitis related arthritis? **YES**___ **NO**___

12. 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**___

13. Is the beneficiary on any other injectable immunomodulator? **YES**___ **NO**___

14. Has the beneficiary been screened for latent tuberculosis infection? **YES**___ **NO**___

15. Has the beneficiary been tested with Hep B SAG and Core Ab? **YES**__ **NO**__ Date of lab and result:
____
____

16. Has the beneficiary tried one systemic corticosteroid (e.g. prednisone, methylprednisolone) or methotrexate, leflunomide or sulfasalazine with inadequate response or is unable to take these therapies due to contraindications? **YES**___ **NO**___
List meds tried or reason beneficiary cannot use corticosteroid, methotrexate, leflumomide or sulfasalazine:
____
____

17. 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: **(800) 678-3189** Pharmacy PA Call Center: **(866) 799-5318**