NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

WellCare
Beyond Healthcare. A Better You.

Ulcerative Colitis - (Humira and Simponi)

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 a diagnosis of Ulcerative Colitis? **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 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**