SANDHILLS CENTER

Pharmacy Request for Prior Approval – 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. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: __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 to: 1-833-727-3741 or Call PerformRx for help: 1-888-846-1062