

**NC Pharmacy Prior Approval Request for
Immunomodulators: Adult Onset Still's Disease
(Ilaris)**

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 Adult Onset Still's Disease? **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. Does the beneficiary have systemic arthritis with active systemic features and features of poor prognosis, as determined by the prescribing physician (e.g. arthritis of the hip, radiographic damage)? **Yes** **No**

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.