Crohn's Disease — Adult (Humira, Cimzia, Entyvio, Inflectra, Stelara, Stelara Infusion, Remicade, Renflexis) Prior Authorization Form

Member Information

1. Member Last Name:_____ 2. First Name:_____

3. Member ID #:_____ 4. Member Date of Birth:_____ 5. Member 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. Length of therapy____

10. Does the member have moderate to severe Crohn's disease? **YES**___ **NO**___

11. Is the member age 18 or greater? **YES**___ **NO**___

12. Is the member on any other injectable immunomodulator? **YES**___ **NO**___

13. Has the member been screened for latent tuberculosis infection? **YES**___ **NO**___

14. Has the member been tested with Hep B SAG and Core Ab? **YES**___ **NO**____
Date of lab and result_____

15. If requesting a non-preferred, list preferred tried or reason member cannot use **one** 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 **1-844-376-2318**
Healthy Blue Pharmacy PA Call Center: **1-844-594-5072**

https://provider.healthybluenc.com

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