

**NC Pharmacy Prior Approval Request for
Immunomodulators: Cytokine Release Syndrome
(Actemra Infusion and Actemra SQ)**

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 Cytokine Release Syndrome? 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

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.