Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Epinephrine Products

Member Information

1. Last Name: _____ 2. First Name: _____
3. Trillium ID #: _____ 4. Date of Birth: _____ 5. Gender: _____

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
5. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: _____ 2. Strength: _____ 3. Quantity per 30 Days: _____
4. Length of Therapy (in Days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days
   ☐ Other_____

Clinical Information

Preferred Products:

1. Is the requested quantity for more than six (6) pens per 180 days? ☐ **Yes** ☐ **No**
2. Prescriber please submit reasoning for medical necessity of the quantity limit exceeding the allowable maximum of six (6) pens. _____

Non-Preferred Products:

3. ☐ Failed two preferred drug(s). If only one preferred drug is available, then failed one preferred drug.
   List preferred drugs failed:_____
   a. Was the failure due to an allergic reaction? ☐ **Yes** ☐ **No**
   b. Was the failure due to a drug-to-drug interaction? ☐ **Yes** ☐ **No**
   Please describe reaction: _____
4. ☐ Previous episode of an unacceptable side effect or therapeutic failure.
   Please provide clinical information:_____
5. ☐ Clinical contraindication, co-morbidity, or unique member circumstance as a contraindication to preferred drug(s). Please provide clinical information: _____
6. ☐ Age specific indications. Please give member age and explain:_____
   _____
7. ☐ Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a general reference:_____
8. ☐ Unacceptable clinical risk associated with therapeutic change. Please explain: _____
   _____
9. Is the requested quantity for more than six (6) pens per 180 days? ☐ **Yes** ☐ **No**
10. Prescriber please submit reasoning for medical necessity of the quantity limit exceeding the allowable maximum of six (6) pens. _____
    _____

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 PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277