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

GLP-1 Receptor Agonists and Combinations

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

Requests for GLP-1 Receptor Agonists and Combinations (Initial):

1. Does the member have a diagnosis of Type 2 Diabetes? ☐ **Yes** ☐ **No**

2. Has the member had a trial and failure or insufficient response to metformin containing products? ☐ **Yes** ☐ **No**

3. Has the member had a contraindication or adverse event to metformin? ☐ **Yes** ☐ **No**

List: ____

4. Does the member have established ASCVD? ☐ **Yes** ☐ **No**

5. Does the member have Chronic Kidney Disease? ☐ **Yes** ☐ **No**

6. For non-preferred products (in addition to questions 1-5), Has the member tried and failed or experienced an insufficient response to at least two preferred products or have a clinical reason that preferred products cannot be tried? ☐ **Yes** ☐ **No**

List: ____

Continuation Requests for GLP-1 Receptor Agonists and Combinations for both preferred and non-preferred products:

1. Has the member improved while on this medication? ☐ **Yes** ☐ **No (Medical Documentation should be attached to this request)**

2. Are individual clinical goals that were set by the provider being met? ☐ **Yes** ☐ **No**

3. Is the member continuing to make adequate progress towards treatment goals? ☐ **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.

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