Trillium Health Resources
Pharmacy Prior Approval Request for

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

Standard Drug Request Form

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: _____
3. 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

1. ☐ 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: _____
2. ☐ Previous episode of an unacceptable side effect or therapeutic failure.
Please provide clinical information: _____
3. ☐ Clinical contraindication, co-morbidity, or unique member circumstance as a contraindication to preferred drug(s). Please provide clinical information: _____
4. ☐ Age specific indications. Please give member age and explain: _____
5. ☐ Unique clinical indication supported by FDA approval or peer reviewed literature.
Please explain and provide a general reference: _____
6. ☐ Unacceptable clinical risk associated with therapeutic change.
Please explain: _____

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