Immunomodulators - Crohn's Disease (Adult): Humira, Avsola, Cimzia, Entyvio, Inflectra, Stelara, Stelara Infusion, Remicade, and Renflexis

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: _____

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 member have a diagnosis of moderate to severe Crohn's Disease? ☐ **Yes** ☐ **No**
2. Is the member 18 years of age or older? ☐ **Yes** ☐ **No**
3. Is the member on any other injectable Immunomodulator? ☐ **Yes** ☐ **No**
4. Has the member been screened for latent tuberculosis infection? ☐ **Yes** ☐ **No**
5. Has the member been tested with Hep B SAG and Core Ab? ☐ **Yes** ☒ **No**
6. Has the member tried and failed Humira? ☐ **Yes** ☐ **No**
   a. If No, Please provide the clinical reason why the member has not tried Humira: _____
   _____

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