

Immunomodulators - Crohn's Disease (Pediatric): Humira, Avsola, Inflectra, 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: 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 moderate to severe Crohn's Disease? Yes No
2. Is the beneficiary 17 years of age or younger? Yes No
3. Is the beneficiary on any other injectable immunomodulator? Yes No
4. Has the beneficiary been screened for latent tuberculosis infection? Yes No
5. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes No
6. Has the beneficiary tried and failed Humira? Yes No
 - a. If No, Please provide the clinical reason why the beneficiary 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.