Trillium Health Resources
Pharmacy Prior Approval Request for

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

Immunomodulators: Enbrel

Member Information

1. Member Last Name: _____ 2. First Name: _____
3. Member ID #: _____4. Member Date of Birth: _____ 5. Member Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name:_____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days ☐ Other _____

Clinical Information

Request for Ankylosing Spondylitis

1. Does the member have a diagnosis of Ankylosing Spondylitis? ☐ **Yes** ☐ **No**
2. Is the member not on another injectable biologic immunomodulator? ☐ **Yes** ☐ **No**
3. Has the member been considered and screened for the presence of latent tuberculosis infection? ☐ **Yes** ☐ **No**
4. Has the member been tested with Hep B SAG and Core Ab? ☐ **Yes** ☐ **No**
5. Has the member experienced inadequate symptom relief from treatment with at least two NSAIDS? ☐ **Yes** ☐ **No**
6. Is member unable to receive treatment with NSAIDS due to contraindications? ☐ **Yes** ☐ **No**
7. Does the member have clinical evidence of severe or rapidly progressing disease? ☐ **Yes** ☐ **No**

Request for Polyarticular Juvenile Idiopathic Arthritis (PJIA)

1. Does the member have a diagnosis of Polyarticular Juvenile Idiopathic Arthritis? ☐ **Yes** ☐ **No**
2. Is the member not on another injectable biologic immunomodulator? ☐ **Yes** ☐ **No**
3. Has the member been considered and screened for the presence of latent tuberculosis infection? ☐ **Yes** ☐ **No**
4. Has the member been tested with Hep B SAG and Core Ab? ☐ **Yes** ☐ **No**
5. Has the member tried one systemic corticosteroid (e.g. prednisone, methylprednisolone) or methotrexate, leflunomide or sulfasalazine with inadequate response or is unable to take these therapies due to contraindications? ☐ **Yes** ☐ **No**
6. Does the member have PJIA subtype enthesitis related arthritis? ☐ **Yes** ☐ **No**

Request for Plaque psoriasis (Pediatric)

1. Does the member have a diagnosis of plaque psoriasis and is a candidate for systemic therapy or phototherapy? ☐ **Yes** ☐ **No**
2. Is the member not on another injectable biologic immunomodulator? ☐ **Yes** ☐ **No**
3. Has the member been considered and screened for the presence of latent tuberculosis infection? ☐ **Yes** ☐ **No**
4. Has the member been tested with Hep B SAG and Core Ab? ☐ **Yes** ☐ **No**
5. Has the member experienced a therapeutic failure/inadequate response with or has a contraindication or intolerance to methotrexate? ☐ **Yes** ☐ **No**
6. Does the member have body surface area (BSA) involvement of at least 3%? ☐ **Yes** ☐ **No**

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7. Does the member have involvement of the palms, soles, head and neck, or genitalia, causing disruption in normal daily activities and/or employment? ☐ **Yes** ☐ **No**

Request for Plaque psoriasis (Adult)

1. Does the member have a documented definitive diagnosis of moderate-to-severe Chronic Plaque Psoriasis? ☐ **Yes** ☐ **No**
2. Is the member 18 years of age or older? ☐ **Yes** ☐ **No**
3. Is the member not on another injectable biologic immunomodulator? ☐ **Yes** ☐ **No**
4. Has the member been considered and screened for the presence of latent tuberculosis infection (not required for Otezla)? ☐ **Yes** ☐ **No**
5. Has the member been tested with Hep B SAG and Core Ab (not required for Otezla)? ☐ **Yes** ☐ **No**
6. Does the member have body surface area (BSA) involvement of at least 3%? ☐ **Yes** ☐ **No**
7. Has the member had involvement of the palms, soles, head and neck, or genitalia, causing disruption in normal daily activities and/or employment? ☐ **Yes** ☐ **No**
8. Has the member failed to respond to, or has been unable to tolerate phototherapy and **ONE** of the following medications or member has contraindications to these treatments: Soriatane (acitretin), Methotrexate, or Cyclosporine? ☐ **Yes** ☐ **No**
9. Has the member had a trial and failure of Cosentyx, Enbrel or Humira or a clinical reason member cannot try Cosentyx, Enbrel or Humira? ☐ **Yes** ☐ **No**
10. Are beneficiaries, Providers, and Pharmacies utilizing Siliq registered appropriately in the Siliq Risk Evaluation and Mitigation Strategy Program (REMS program) ? ☐ **Yes** ☐ **No**

Request for Psoriatic Arthritis

1. Does the member have a documented definitive diagnosis of Psoriatic Arthritis? ☐ **Yes** ☐ **No**
2. Is the member 18 years of age or older (OR 2 years or older for Simponi Aria)? ☐ **Yes** ☐ **No**
3. Is the member not on another injectable biologic immunomodulator? ☐ **Yes** ☐ **No**
4. Has the member been considered and screened for the presence of latent tuberculosis infection? ☐ **Yes** ☐ **No**
5. Has the member been tested with Hep B SAG and Core Ab (not required for Otezla)? ☐ **Yes** ☐ **No**
6. Does the member have a documented inadequate response or inability to take methotrexate ☐ **Yes** ☐ **No**

Request for Rheumatoid Arthritis

1. Does the member have a diagnosis of Rheumatoid Arthritis? ☐ **Yes** ☐ **No**
2. Is the member not on another injectable biologic immunomodulator? ☐ **Yes** ☐ **No**
3. Has the member been considered and screened for the presence of latent tuberculosis? ☐ **Yes** ☐ **No**
4. Has the member been tested with Hep B SAG and Core Ab? ☐ **Yes** ☐ **No**
5. Has the member experienced a therapeutic failure/inadequate response with methotrexate or at least one disease modifying antirheumatic drug (e.g. leflunomide, hydroxychloroquine, minocycline, sulfasalazine)? ☐ **Yes** ☐ **No**
6. Is the member unable to receive methotrexate or disease modifying antirheumatic drug due to contraindications or intolerabilities? ☐ **Yes** ☐ **No**
7. Does the member have clinical evidence of severe or rapidly progressing disease? ☐ **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