Trillium Health Resources
Pharmacy Prior Approval Request for

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

Immunomodulators: Entyvio

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 Crohn's Disease (Adult)

1. Does the member have a diagnosis of moderate to severe Crohn's Disease? ☐ **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 had a trial and failure of Humira or a clinical reason member cannot try Humira? ☐ **Yes** ☐ **No**

Request for Ulcerative Colitis (Adult)

1. Does the member have a diagnosis of ulcerative colitis? ☐ **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 had a trial and failure of Humira or a clinical reason member cannot try Humira? ☐ **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.