Trillium Health Resources
Pharmacy Prior Approval Request for

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

Immunomodulators: Orencia

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 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**
7. Has the member had a trial and failure of Enbrel or Humira or a clinical reason member cannot try Enbrel or Humira? ☐ **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? ☐ **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 documented inadequate response or inability to take methotrexate? ☐ **Yes** ☐ **No**
7. Has the member had a trial and failure of Cosentyx, Enbrel or Humira or a clinical reason member cannot try either Cosentyx, Enbrel or Humira? ☐ **Yes** ☐ **No**

Request for <u>Rheumatoid arthritis</u>

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 infection? ☐ **Yes** ☐ **No**

4. Has the member been tested with Hep B SAG and Core Ab? ☐ **Yes** ☐ **No**
5. Does the member have a body surface area (BSA) involvement of at least 3%? ☐ **Yes** ☐ **No**
6. 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**
7. Is the member unable to receive methotrexate or disease modifying antirheumatic drug due to contraindications or intolerability? ☐ **Yes** ☐ **No**
8. Does the member have clinical evidence of severe or rapidly progressing disease? ☐ **Yes** ☐ **No**
9. Has the member had a trial and failure of Enbrel or Humira or a clinical reason member cannot try either Enbrel or Humira? ☐ **Yes** ☐ **No**

Request for Prophylaxis of acute Graft versus Host Disease (aGVHD)
1 Is the member undergoing hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele-mismatched unrelated-donor? ☐ **Yes** ☐ **No**
2. Is the member 2 years of age or older? ☐ **Yes** ☐ **No**
3. Is the member taking in combination with a calcineurin inhibitor and methotrexate? ☐ **Yes** ☐ **No**
4. Is the member not on another injectable biologic immunomodulator? ☐ **Yes** ☐ **No**
5. Has the member been considered and screened for the presence of latent tuberculosis infection? ☐ **Yes** ☐ **No**
6. Has the member been tested with Hep B SAG and Core Ab? ☐ **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.