Trillium Health Resources
Pharmacy Prior Approval Request for

Immunomodulators - Plaque Psoriasis (Adult): Enbrel, Humira, Cosentyx, Avsola, Cimzia, Ilumya, Inflectra, Otezla, Remicade, Renflexis, Siliq, Skyrizi, Stelara, Taltz, and Tremfya

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. Is the member age 18 or older? ☐ **Yes** ☐ **No**
2. Does the member have a diagnosis of moderate to severe chronic Plaque Psoriasis? ☐ **Yes** ☐ **No**
3. **I**s 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 failed to respond to, or has been unable to tolerate phototherapy and One of the following medications (methotrexate, cyclosporine, or soritane) for plaque psoriasis or has contraindications to these treatments? ☐ **Yes** ☐ **No**
7. Does the member have a body surface area (BSA) involvement of at least 3%? ☐ **Yes** ☐ **No**
8. 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**
9. Has the member tried and failed Cosentyx, Enbrel, or Humira? ☐ **Yes** ☐ **No**
   a. If no, please provide the clinical reason why the member has not tried Cosentyx, Enbrel, or Humira:_____
   _____

For coverage of Siliq (Answer questions 1 - 11):

10. Is the member registered in the Siliq Risk Evaluation and Mitigation Program (REMS Program)? ☐ **Yes** ☐ **No**
11. Is the prescribing provider registered in the Siliq Risk Evaluation and Mitigation Program (REMS Program)? ☐ **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