

Immunomodulators - Polyarticular Juvenile Idiopathic Arthritis (PJIA): Enbrel, Humira, Actemra SQ, Actemra Infusion, Simponi Aria, Orencia SQ, Orencia Infusion, and Xeljanz

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. Does the member have a diagnosis of Polyarticular Juvenile Idiopathic Arthritis? Yes No
2. Is the member on any other injectable immunomodulator? Yes No
3. Has the member been screened for 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 any of the following with inadequate response:
 - Systemic corticosteroid or methotrexate
 - Leflunomide or sulfasalazine
 - Unable to take them due to contraindications
6. Does the member have PJIA subtype enthesitis related arthritis? Yes No
7. Has the member tried and failed Enbrel or Humira? Yes No
 - a. If No, Please provide the clinical reason why the member has not tried Enbrel or 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.

Fax this form to PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277