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

Immunomodulators - Psoriatic Arthritis: Enbrel, Humira, Cosentyx, Avsola, Cimzia, Inflectra, Orencia SQ, Orencia Infusion, Otezla, Remicade, Renflexis, Simponi, Simponi Aria, Stelara, Taltz, Tremfya, Xeljanz and Xeljanz XR

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. **For Simponi Aria**: is the member age 2 or older? ☐ **Yes** ☐ **No**
3. Does the member have a definitive diagnosis of psoriatic arthritis? ☐ **Yes** ☐ **No**
4. Is the member on any other injectable immunomodulator? ☐ **Yes** ☐ **No**
5. Has the member been screened for latent tuberculosis infection? ☐ **Yes** ☐ **No**
6. Has the member been tested with Hep B SAG and Core Ab? ☐ **Yes** ☐ **No**
7. Does the member have a documented inadequate response or inability to take methotrexate? ☐ **Yes** ☐ **No**
8. 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: ___
   ____

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