**Trillium Health Resources**
**Pharmacy Prior Approval Request for**

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

# Immunomodulators: Taltz

**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**

**Requests for Ankylosing Spondylitis:**

1. Does the member have a diagnosis of Ankylosing Spondylitis? ☐ **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 experienced inadequate symptom relief from treatment with at least two NSAIDS? ☐ **Yes** ☐ **No**
6. Is the member unable to receive treatment with NSAIDS due to contraindications? ☐ **Yes** ☐ **No**
7. Does the member have clinical evidence of severe or rapidly progressing disease? ☐ **Yes** ☐ **No**
8. Has the member had a trial and failure of Cosentyx, Enbrel or Humira or have a clinical reason they cannot try Cosentyx, Enbrel or Humira? ☐ **Yes** ☐ **No**

**Requests for Plaque psoriasis (Pediatric):**

1. Does the member have a diagnosis of plaque psoriasis and is a candidate for systemic therapy or phototherapy? ☐ **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 experienced a therapeutic failure/inadequate response with or has a contraindication or intolerance to methotrexate? ☐ **Yes** ☐ **No**
6. Does the member have body surface area (BSA) involvement of at least 3%? ☐ **Yes** ☐ **No**
7. 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**

8. For ages 6 and up has there been a trial and failure of Cosentyx, Enbrel or Humira or have a clinical reason they cannot try Cosentyx, Enbrel or Humira? ☐ **Yes** ☐ **No**

**Requests for Plaque psoriasis (Adult):**

1. Does the member have a documented definitive diagnosis of moderate-to-severe Chronic Plaque Psoriasis? ☐ **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? ☐ **Yes** ☐ **No**
5. Has the member been tested with Hep B SAG and Core Ab? ☐ **Yes** ☐ **No**
6. Does the member have body surface area (BSA) involvement of at least 3%? ☐ **Yes** ☐ **No**
7. Does the member have involvement of the palms, soles, head and neck, or genitalia, causing disruption in normal daily activities and/or employment?
8. Has the member failed to respond to, or has been unable to tolerate phototherapy and **ONE** of the following medications or member has contraindications to these treatments: Soriatane (acitretin), Methotrexate, and/or Cyclosporine? ☐ **Yes** ☐ **No**
9. Has the member had a trial and failure of Cosentyx, Enbrel or Humira or have a clinical reason they cannot try Cosentyx, Enbrel or Humira? ☐ **Yes** ☐ **No**

**Requests 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? ☐ **Yes** ☐ **No**
5. Has the member been tested with Hep B SAG and Core Ab? ☐ **Yes** ☐ **No**
6. Does the member have a 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 have a clinical reason they cannot try Cosentyx, Enbrel or Humira? ☐ **Yes** ☐ **No**

**Requests for Non-Radiographic Axial Spondylorarthritis:**

1. Does the member have a diagnosis of Non-Radiographic Axial Spondyloarthritis? ☐ **Yes** ☐ **No**
2. Is the member not on another injectable biologic immunomodulator? ☐ **Yes** ☐ **No**
3. Has the member failed an adequate trial of a Non-Steroidal Anti-Inflammatory Drug (NSAID) unless contraindicated? ☐ **Yes** ☐ **No**
4. Has the member been considered and screened for the presence of latent tuberculosis infection? ☐ **Yes** ☐ **No**
5. Has the member been tested with Hep B SAG and Core Ab? ☐ **Yes** ☐ **No**
6. Has the member had a trial and failure of Cosentyx or a clinical reason member cannot try Cosentyx? ☐ **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.