Trillium Health Resources
Pharmacy Prior Approval Request for

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

Immunomodulators: Uplinza

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 Neuromyelitis Optica Spectrum Disorder (NMOSD)

1. Does the member have a diagnosis of Neuromyelitis Optica Spectrum Disorder? ☐ **Yes** ☐ **No**
2. Is the member anti-aquaporin-4 (AQP4) antibody positive? ☐ **Yes** ☐ **No**
3. Is the member 18 years of age or older? ☐ **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.