Trillium Health Resources
Pharmacy Prior Approval Request for

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

Immunomodulators: Xeljanz XR

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 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 individual risks and benefits been considered prior to initiating or continuing therapy in those at higher risk for malignancy and/or major adverse cardiovascular events (MACE)? ☐ **Yes** ☐ **No**
4. Is the member NOT considered to be at high risk for thrombosis? ☐ **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**
7. Will the member NOT receive live vaccines during therapy? ☐ **Yes** ☐ **No**
8. Has the member tried at least one Tumor Necrosis Factor Blocker with inadequate response or unable to take these therapies due to intolerance or contraindications? ☐ **Yes** ☐ **No**
9. Has the member had a trial and failure of Cosentyx, Enbrel or Humira or a clinical reason member cannot try Cosentyx, Enbrel or Humira? ☐ **Yes** ☐ **No**

Request 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 individual risks and benefits been considered prior to initiating or continuing therapy in those at higher risk for malignancy and/or major adverse cardiovascular events (MACE)? ☐ **Yes** ☐ **No**
5. Is the member NOT considered to be at high risk for thrombosis? ☐ **Yes** ☐ **No**
6. Has the member been considered and screened for the presence of latent tuberculosis infection? ☐ **Yes** ☐ **No**
7. Has the member been tested with Hep B SAG and Core Ab? ☐ **Yes** ☐ **No**

8. Does the member have a documented inadequate response, intolerance or contraindication to at least one Tumor Necrosis Factor Blocker? ☐ **Yes** ☐ **No**
9. Has the member had a trial and failure of Cosentyx, Enbrel or Humira or a clinical reason member cannot try Cosentyx, Enbrel or Humira? ☐ **Yes** ☐ **No**

Request for Rheumatoid Arthritis

1. Does the member have a diagnosis of Rheumatoid Arthritis? ☐ **Yes** ☐ **No**
2. Is the member not on another injectable biologic immunomodulator? ☐ **Yes** ☐ **No**
3. Has the member individual risks and benefits been considered prior to initiating or continuing therapy in those at higher risk for malignancy and/or major adverse cardiovascular events (MACE)? ☐ **Yes** ☐ **No**
4. Is the member NOT considered to be at high risk for thrombosis? ☐ **Yes** ☐ **No**
5. Has the member been considered and screened for the presence of latent tuberculosis? ☐ **Yes** ☐ **No**
6. Has the member been tested with Hep B SAG and Core Ab? ☐ **Yes** ☐ **No**
7. Will the member NOT receive live vaccines during therapy? ☐ **Yes** ☐ **No**
8. Has the member experienced a therapeutic failure/inadequate response with at least one Tumor Necrosis Factor Blocker? ☐ **Yes** ☐ **No**
9. Is the member unable to receive Tumor Necrosis Factor Blocker due to contraindications or intolerabilities? ☐ **Yes** ☐ **No**
10. Has the member had a trial and failure of Enbrel or Humira or a clinical reason member cannot try Enbrel or Humira? ☐ **Yes** ☐ **No**

Request for Ulcerative Colitis (Adult)

1. Does the member have a diagnosis of ulcerative colitis? ☐ **Yes** ☐ **No**
2. Is the member not on another injectable biologic immunomodulator? ☐ **Yes** ☐ **No**
3. Has the member individual risks and benefits been considered prior to initiating or continuing therapy in those at higher risk for malignancy and/or major adverse cardiovascular events (MACE)? ☐ **Yes** ☐ **No**
4. Is the member NOT considered to be at high risk for thrombosis? ☐ **Yes** ☐ **No**
5. Has the member been considered and screened for the presence of latent tuberculosis? ☐ **Yes** ☐ **No**
6. Has the member been tested with Hep B SAG and Core Ab? ☐ **Yes** ☐ **No**
7. Will the member NOT receive live vaccines during therapy? ☐ **Yes** ☐ **No**
8. Has the member had a trial and failure of Humira or a clinical reason member cannot try Humira? ☐ **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.