Trillium Health Resources
Pharmacy Prior Approval Request for

Immunomodulators: Inflectra

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 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 or is unable to receive treatment with NSAIDS due to contraindications or has clinical evidence of severe or rapidly progressing disease? ☐ **Yes** ☐ **No**
6. 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 Crohn's Disease (Adult)
1. Does the member have a diagnosis of moderate to severe Crohn's Disease? ☐ **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 had a trial and failure of Humira or a clinical reason member cannot try Humira? ☐ **Yes** ☐ **No**

Request for Crohn's Disease (Pediatric)
1. Does the member have a diagnosis of moderate to severe Crohn's Disease? ☐ **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 had a trial and failure of Humira or a clinical reason member cannot try Humira? ☐ **Yes** ☐ **No**

Request 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 (not required for Otezla)? ☐ **Yes** ☐ **No**
5. Has the member been tested with Hep B SAG and Core Ab? ☐ **Yes** ☐ **No**
6. Does the member have a 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. 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 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 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 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 been considered and screened for the presence of latent tuberculosis? ☐ **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 methotrexate or at least one disease modifying antirheumatic drug (e.g. leflunomide, hydroxychloroquine, minocycline, sulfasalazine) ? ☐ **Yes** ☐ **No**
6. Is the member unable to receive methotrexate or disease modifying antirheumatic drug due to contraindications or intolerabilities? ☐ **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 Enbrel or Humira or a clinical reason member cannot try Enbrel or Humira? ☐ **Yes** ☐ **No**

Trillium Health Resources
Pharmacy Prior Approval Request for

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 been considered and screened for the presence of latent tuberculosis? ☐ **Yes** ☐ **No**
4. Has the member been tested with Hep B SAG and Core Ab? ☐ **Yes** ☐ **No**
5. 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.