PRIOR AUTHORIZATION REQUEST
Enbrel

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. Will the requested medication be used in combination with a BIOLOGIC disease-modifying antirheumatic drug (DMARD) or targeted Synthetic disease-modifying antirheumatic drug?
   - ☐ Biologic DMARD
   - ☐ Targeted synthetic DMARD
   - ☐ Conventional synthetic DMARD
   - ☐ No, the requested medication will NOT be used in combination with another BIOLOGIC or Targeted Synthetic disease-modifying antirheumatic drug (DMARD)
2. ☐ Yes ☐ No Is the patient currently receiving an etanercept product?
3. What is the indication or diagnosis?
   - ☐ Rheumatoid arthritis - **Please answer questions 4, 5, 28 & 33**
   - ☐ Juvenile idiopathic arthritis (JIA) [or JRA](regardless of type of onset) - This includes patients with Juvenile spondyloarthropathy/active sacroiliac arthritis - **Please answer questions 8 – 10, 29 & 33**
   - ☐ Psoriatic arthritis (PsA) - **Please answer questions 7 & 30**
   - ☐ Plaque psoriasis - **Please answer questions 6, 11 – 13 & 31**
   - ☐ Ankylosing spondylitis **- Please answer questions 32 & 33**
   - ☐ Spondyloarthritis (SpA), other subtypes (for example, undifferentiated arthritis, non-radiographic axial SpA, Reactive Arthritis [Reiter's disease]) - **Please answer questions 16 – 20, 32 & 33**
   - ☐ Still's Disease (systemic-onset RA in adults, the disease may have begun in childhood) **- Please answer questions 24, 31 & 33**
   - ☐ Uveitis (including other posterior uveitides and panuveitis syndromes) - **Please answer questions 14, 25 & 34**
   - ☐ Scleritis or Sterile Corneal Ulceration - **Please answer questions 15, 25 & 35**
   - ☐ Graft-versus-host disease (GVHD) **- Please answer questions 21, 26 & 36**
   - ☐ Behcet's disease - **Please answer questions 22, 27 & 31**
   - ☐ Pyoderma gangrenosum - **Please answer questions 13, 23 & 31**

If you have any questions, call: 800-753-2851

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- ☐ Large Vessel Vasculitis (for example, giant cell arteritis, Takayasu's arteritis)
- ☐ Polymyalgia rheumatica (PMR)
- ☐ Hidradenitis suppurativa
- ☐ Crohn's Disease
- ☐ Wegener's granulomatosis
- ☐ Sarcoidosis
- ☐ Inflammatory myopathies (dermatomyositis, polymyositis, inclusion body myositis)
- ☐ All other indications or diagnoses (Please specify): _____

4. ☐ Yes ☐ No Has the patient tried ONE conventional synthetic disease-modifying antirheumatic drug (DMARD) for at least 3 months?
5. ☐ Yes ☐ No Has the patient tried at least one biologic disease-modifying antirheumatic drug (DMARD) for at least 3 months?
6. ☐ Yes ☐ No Has the patient tried at least one traditional systemic agent for psoriasis for at least 3 months, unless intolerant?
7. ☐ Yes ☐ No Is the requested medication prescribed by or in consultation with a rheumatologist or a dermatologist?
8. ☐ Yes ☐ No Has the patient tried one other agent for this condition or will be starting on the requested medication concurrently with methotrexate, sulfasalazine, or leflunomide?
9. ☐ Yes ☐ No Does the patient have an absolute contraindication to methotrexate, suflasalazine, or leflunomide?
10. ☐ Yes ☐ No Has the prescriber determined that the patient has aggressive disease?
11. ☐ Yes ☐ No Has the patient already had a 3-month trial or previous intolerance to at least one biologic?
12. ☐ Yes ☐ No Does the patient have a contraindication to methotrexate, as determined by the prescriber?
13. ☐ Yes ☐ No Is the requested medication prescribed by or in consultation with a dermatologist?
14. ☐ Yes ☐ No Has the patient tried one of the following therapies for this condition: periocular, intraocular, or systemic corticosteroids, or immunosuppressives; OR an adalimumab product, or an infliximab product?
15. ☐ Yes ☐ No Has the patient tried one other therapy for these conditions?
16. ☐ Yes ☐ No Does the patient have arthritis primarily in the knees, ankles, elbows, wrists, hands and/or feet?
17. ☐ Yes ☐ No Has the patient tried at least ONE conventional synthetic DMARD?
18. ☐ Yes ☐ No Does the patient have axial spondyloarthritis?
19. ☐ Yes ☐ No Does the patient have objective signs of inflammation, defined as: a C-reactive protein (CRP) elevated beyond the upper limit of normal for the reporting laboratory?
20. ☐ Yes ☐ No Does the patient have objective signs of inflammation, defined as: sacroiliitis reported on magnetic resonance imaging (MRI)?
21. ☐ Yes ☐ No Has the patient tried one conventional treatment for graft-versus-host disease or will

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be concurrently receiving at least one conventional treatment in combination with an etanercept product?

22. □ Yes □ No Has the patient tried at least one conventional therapy OR at least one tumor necrosis factor inhibitor?
23. □ Yes □ No Has the patient tried one other immunosuppressant for at least 2 months or was intolerant to one of these agents OR tried one systemic corticosteroid?
24. □ Yes □ No Has the patient tried a corticosteroid AND one conventional synthetic DMARD (disease modifying antirheumatic drug) given for at least 2 months or was intolerant to a conventional synthetic DMARD?
25. □ Yes □ No Is the requested medication prescribed by or in consultation with an ophthalmologist?
26. □ Yes □ No Is the requested medication prescribed by or in consultation with an oncologist, hematologist, or a physician affiliated with a transplant center?
27. □ Yes □ No Is the requested medication prescribed by or in consultation with a rheumatologist, dermatologist, ophthalmologist, gastroenterologist, or neurologist?
28. □ Yes □ No Has the patient had a response to an etanercept product, as determined by the prescriber?
29. □ Yes □ No Has the patient had a response to an etanercept product, as determined by the prescriber?
30. □ Yes □ No Has the patient had a response, as determined by the prescriber?
31. □ Yes □ No Has the patient had a response as determined by the prescriber? The patient may not have a full response, but there should have been a recent or past response to an etanercept product.
32. □ Yes □ No Has the patient had a response to an etanercept product, as determined by the prescriber?
33. □ Yes □ No Is the requested medication prescribed by or in consultation with a rheumatologist?
34. □ Yes □ No Has the patient had a response to an etanercept product, as determined by the prescriber?
35. □ Yes □ No Has the patient had a response to an etanercept product, as determined by the prescriber?
36. □ Yes □ No Has the patient responded to therapy, as determined by the prescriber?

Please document the diagnoses, symptoms, and/or any other information important to this review:

_____

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SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

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