PRIOR AUTHORIZATION REQUEST

ENBREL

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Will the requested medication be used in combination with a biologic disease-modifying antirheumatic drug (DMARD) or targeted synthetic DMARD? [Note: Examples of biologics include but not limited to adalimumab SC products (Humira, biosimilars), Actemra (IV or SC), Cimzia, Cosentyx, Kevzara, Kineret, Orencia (IV or SC), an infliximab product (for example, Remicade, biosimilars), rituximab IV products (Rituxan, biosimilars), Siliq, Stelara (IV or SC), Taltz, Ilumya, Skyrizi, Tremfya, Entyvio, or Simponi (Aria	Yes	No

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PRIOR AUTHORIZATION REQUEST

	or SC). Examples of targeted synthetic DMARD include but not limited to Olumiant, Rinvoq, Xeljanz/XR, Otezla.] [If yes, no further questions.]		
2	Is the patient currently receiving an etanercept product? [If no, skip to question 7.]	Yes	No
3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 7.]	Yes	No
4	Does the patient have a previously approved PA on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a clinically significant response, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	What is the indication or diagnosis? [] Rheumatoid Arthritis (If checked, go to 8) [] Ankylosing Spondylitis (If checked, go to 13) [] Psoriatic Arthritis (PsA) (If checked, go to 17) [] Juvenile Idiopathic Arthritis (JIA) (or Juvenile Rheumatoid Arthritis [JRA]) regardless of type of onset. [Note: This includes patients with juvenile spondyloarthropathy/active sacroiliac arthritis] (If checked, go to 22) [] Juvenile Psoriatic Arthritis (JPsA) (If checked, go to 22) [] Plaque Psoriasis (If checked, go to 29) [] Other (If checked, no further questions)		
8	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
9	Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or failed treatment for at least 3 months with at least TWO conventional systemic therapies (such as leflunomide, hydroxychloroquine, sulfasalazine, or methotrexate)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
10	Has documentation been submitted to confirm that the patient has had a treatment failure with an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-adbm) for at least 3	Yes	No

PRIOR AUTHORIZATION REQUEST

	months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]		
11	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? (Dose: 50 mg once weekly with or without methotrexate [MTX]) [If yes, no further questions.]	Yes	No
12	Is the requested medication prescribed by, or in consultation with, a rheumatologist? [No further questions.]	Yes	No
13	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
14	Has documentation been submitted to confirm that the patient has had a treatment failure with an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-adbm) for at least 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
15	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? (Dose: 50 mg once weekly) [If yes, no further questions.]	Yes	No
16	Is the requested medication prescribed by, or in consultation with, a rheumatologist? [No further questions.]	Yes	No
17	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
18	Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or failed treatment for at least 3 months with at least TWO conventional systemic therapies (such as leflunomide, hydroxychloroquine, sulfasalazine, or methotrexate)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
19	Has documentation been submitted to confirm that the patient has had a treatment failure with an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-adbm) for at least 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
20	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? (Dosing: 50 mg once weekly with or without methotrexate [MTX]) [If yes, no further questions.]	Yes	No
21	Is the requested medication prescribed by, or in consultation with, a rheumatologist or a dermatologist? [No further questions.]	Yes	No

PRIOR AUTHORIZATION REQUEST

22	Is the patient greater than or equal to 2 years of age? [If no, no further questions.]	Yes	No
23	Has the patient tried TWO other agents for at least 3 months for this condition? [Note: Examples of other agents include methotrexate (MTX), sulfasalazine, leflunomide, or a nonsteroidal anti-inflammatory drug (NSAID) (for example, ibuprofen or naproxen).] [If yes, skip to question 25.]	Yes	No
24	Does the patient have an absolute contraindication to methotrexate (MTX), sulfasalazine, or leflunomide? [Note: Examples of contraindications to MTX include pregnancy, breast feeding, alcoholic liver disease, immunodeficiency syndrome, or blood dyscrasias.] [If no, no further questions.]	Yes	No
25	Has documentation been submitted to confirm that the patient has had a treatment failure with an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-adbm) for at least 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
26	Does the patient have aggressive disease, as determined by the prescriber? [If no, no further questions.]	Yes	No
27	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? (Dose: 0.8 mg/kg weekly. Max dose of 50 mg per week) [If yes, no further questions.]	Yes	No
28	Is the requested medication prescribed by, or in consultation with, a rheumatologist or a dermatologist? [No further questions.]	Yes	No
29	Is the patient greater than or equal to 4 years of age? [If no, no further questions.]	Yes	No
30	Has the patient tried at least TWO traditional systemic agents for psoriasis for at least 3 months, unless intolerant? [Note: Examples include methotrexate (MTX), cyclosporine, acitretin (Soriatane, generics).] [If no, no further questions.]	Yes	No
31	Has documentation been submitted to confirm that the patient has had a treatment failure with an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-adbm) for at least 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
32	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? (Dosing: Patients greater than or equal to 18 years of age: 50 mg twice weekly for 3 months followed by 50 mg once weekly. Patients greater than or equal to 4 years of age: 0.8 mg/kg weekly. Max dose of 50 mg per week) [If yes, no further questions.]	Yes	No

PRIOR AUTHORIZATION REQUEST

33	Is the requested medication prescribed by, or in consultation with, a dermatologist?	Yes	No

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

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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If you have any questions, call: 1-888-258-8250

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