ENBREL (ETANERCEPT) [PREFERRED] PRIOR AUTHORIZATION FORM

(form effective 1/1/20)

Keystone First | PERFORMRX℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-215-937-5018**, or to speak to a representative call **1-800-588-6767**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	# of pages:	Name of office contact:
Contact's phone number:		LTC facility contact/phone:

PATIENT INFORMATION

Patient name:	Patient ID #:	DOB:
Street address:	Apt. #:	City/state/zip:

PRESCRIBER INFORMATION

Prescriber name:	Specialty:	
State license #:	NPI:	MA Provider ID #:
Street address:	Suite #:	City/state/zip:
Phone:	Fax:	

CLINICAL INFORMATION

Product requested:	☐ Enbrel 25 mg/0.5 ml syringe ☐ Enbrel 25 mg vial kit	☐ Enbrel 50 mg/ml syringe ☐ Enbrel 50 mg/ml SureClick pen	☐ Enbrel 50 mg/ml mini cartridge ☐ Enbrel:_____
Quantity: _____	Refills: _____	Patient's weight: _____ lbs/kg	
Directions:			
Diagnosis (submit documentation):			Diagnosis code *(required)*:

PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication):

Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Patient's Preferred Pharmacy Name:	
Pharmacy Phone #:	Pharmacy Fax #:
☐ I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.	

INITIAL REQUESTS (Complete questions applicable to patient's diagnosis):

1. ***All diagnoses***: Check all that apply to the patient and submit documentation for each.
   ☐ vaccinated for hepatitis B ☐ screened for tuberculosis ☐ screened for hepatitis B (surface antigen and core antibody)
   ☐ up-to-date with all age-appropriate immunizations ☐ has been using Enbrel in the past 90 days

2. ***Rheumatoid arthritis:*** Does the patient have a history of trial and failure, contraindication, or intolerance of at least 3 months of treatment with methotrexate or another DMARD?
   ☐ Yes – List medications tried:_____
   ☐ No

3. ***Ankylosing spondylitis or psoriatic arthritis:*** Does the patient have a history of trial and failure, contraindication, or intolerance of the following?
   ☐ four-week trial each of at least 2 different NSAIDs ☐ eight-week trial of methotrexate or other DMARD (does not apply to axial disease)
   ☐ Yes – List medications tried:_____
   ☐ No

4. ***ADULT plaque psoriasis:*** Does at least one of the following apply to the patient?
   ☐ at least 5% of body surface area (BSA) is affected ☐ critical areas of the body are involved (face, palms, soles, and/or genitals)
   ☐ Yes ☐ No *Submit documentation*

5. ***ADULT plaque psoriasis:*** Does the patient have a history of trial and failure, contraindication, or intolerance of the following treatments and medications? *Check all that apply.*
   ☐ 3 months PUVA ☐ 3 months UVB light ☐ acitretin ☐ cyclosporine ☐ methotrexate
   ☐ Yes ☐ No *Submit documentation of treatments and medications tried and outcomes.*

6. ***PEDIATRIC plaque psoriasis:*** Submit documentation supporting the diagnosis.

7. ***All other diagnoses:*** Submit documentation supporting the use of Enbrel for the patient's diagnosis and all treatment regimens tried.

RENEWAL REQUESTS

Since starting Enbrel, did the patient experience a positive clinical response and/or improved level of functioning?
☐ Yes ☐ No Submit documentation of clinical response.

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: