ENBREL (ETANERCEPT) [PREFERRED] PRIOR AUTHORIZATION FORM

(form effective 1/5/21)

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 25 mg/0.5 mL vial	☐ 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.
   ☐ 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. ***All diagnoses***: Is Enbrel being prescribed by or in consultation with an appropriate specialist? ☐ Yes - list specialty ___________________________________ ☐ No

3. ***All diagnoses***: Have all potential drug interactions been addressed? ☐ Yes ☐ No ☐ NA - No drug interactions exist

4. ***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 non-biologic DMARD?
   ☐ Yes – List medications tried:____
   ☐ No

5. ***Psoriatic arthritis:*** Does at least one of the following apply to the patient?:
   ☐ axial disease and/or enthesitis and has tried and failed a two-week trial with two different oral NSAIDs
   List medications tried:____
   ☐ peripheral disease and has tried and failed methotrexate or other DMARD
   List medications tried:____
   ☐ severe disease
   ☐ concomitant moderate-to-severe nail disease

6. ***Ankylosing spondylitis***: Does the patient have a history of trial and failure of a two-week trial of continuous treatment with two different oral NSAIDs?
   ☐ Yes – list medications tried:____
   ☐ No

7. ***ADULT plaque psoriasis:*** Does at least one of the following apply to the patient?
   ☐ at least 3% of body surface area (BSA) is affected ☐ critical areas of the body are involved (face, palms, soles, and/or genitals)
   ☐ significant disability or impairment of physical or mental functioning

   ☐ Yes ☐ No *Submit documentation*

8. ***Plaque psoriasis:*** Does the patient have a history of trial and failure, contraindication, or intolerance to topical corticosteroids or other topical therapy?

   ☐ Yes – list medications tried:____
   ☐ No

Coverage by Vista Health Plan, an independent licensee of the Blue Cross and Blue Shield Association.

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

9. ***Plaque psoriasis:*** Does the patient have a history of trial and failure, contraindication, or intolerance to the following? Check all that apply.

☐ oral systemic therapy; list medications tried: ____________________
☐ ultraviolet light therapy

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

11. ***Juvenile idiopathic arthritis (JIA):*** Does at least one of the following apply to the patient?

☐ therapeutic failure of a three-month trial of a conventional non-biologic DMARD; list medications tried: ____________________

☐ contraindication or intolerance to non-biologic DMARDs; provide explanation: ____________________

☐ systemic JIA with active systemic features

☐ JIA that is associated with high disease activity or one or more poor prognostic features

☐ active sacroliitis and/or enthesitis and has tried and failed a two-week trial of an oral NSAID; list medications tried: ____________________

12. ***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.

Is Enbrel being prescribed by or in consultation with an appropriate specialist?

☐ Yes – list specialty: ____________________
☐ No

Have all potential drug interactions been addressed?
☐ Yes
☐ No
☐ NA – no drug interactions exist

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date:

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