

Fax completed form to: 1-866-868-0858
Questions, please call: 1-866-316-6049



Important Information About Prescription Drug Coverage

To: _____ From: _____

Fax: _____ Pages: _____

Re: Enbrel® (etanercept): Prior Authorization Request Form: Please respond.

- Please complete the attached Enbrel® (etanercept) Prior Authorization Request Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

Please note: By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

Information about this drug

Enbrel® (etanercept)

Clinical trial data involving the use of Enbrel® in elderly patients is limited. Use in elderly patients should occur with significant caution, especially if the patient has heart failure, is susceptible to infections or has a history of a demyelinating disease. Screen for latent TB prior to Enbrel® initiation.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.

MemberHealth, LLC, PO Box 391197, Solon OH 44139-3911

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M0018_PATEMP_1107 CMS 11/28/07 H5656

Prior Authorization Request Form



Fax completed form to 1-866-868-0858 Need help? Call 1-866-316-6049

Patient Information

Name _____
Member ID _____
Medicare ID _____
Date of birth _____ Sex: M / F
Address _____
City _____
State _____ ZIP _____
Phone _____
Nursing home resident? YES / NO
Home care patient? YES / NO

Prescriber and Pharmacy Information

Name _____
Specialty _____
DEA _____
NPI _____
Address _____
City _____
State _____ ZIP _____
Phone _____ Fax _____
Pharmacy name _____
NCPDP _____
NPI _____
Phone _____ Fax _____

All items below this line are for Physician Use Only

Information for Requested Drug

Strength: _____ Dosage form: _____ Qty per 30 days: _____ Drug is (circle one): Newly prescribed/Refill
Directions: _____ Diagnosis: _____ ICD-9 Code: _____

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

Enbrel® (etanercept) Criteria

- Please indicate Enbrel®'s dispensing location:
 the physician's supply, incident to a physician's visit
 the pharmacy
 other: _____
- Please indicate the patient's diagnosis. Select or indicate the correct ICD-9 code. This question must be answered.
 Rheumatoid Arthritis (ICD-9: 714)
 Psoriatic Arthritis (ICD-9: 696.0)
 Plaque Psoriasis (ICD-9: 696.1)
 Other (diagnosis and ICD-9 code): _____
 Ankylosing Spondylitis (ICD-9: 720.0)
- Is the prescribing physician a rheumatologist or dermatologist or has one been consulted?
 Yes No
- Does the patient meet any of the following exclusion criteria? If so you must check all that apply. This question must be answered
 Yes No
 Active infection (e.g., chronic leg ulcers, recurrent URIs, indwelling catheter, TB, hepatitis B/C, HIV)
 Septic arthritis of a native joint within the last 12 months
 Sepsis of a prosthetic joint within the last 12 months
- or indefinitely if the joint remains in situ
 NYHA Class 3 or 4 heart failure
 Clear history of demyelinating disease
- For rheumatoid or psoriatic arthritis or ankylosing spondylitis: Has the patient failed to receive a clinically appropriate therapeutic response or demonstrated intolerance (e.g., allergy, hypersensitivity, adverse effects(s), development of a contraindication) to Humira®?
 Yes No
- For plaque psoriasis: Has the patient failed to receive a clinically appropriate therapeutic response OR demonstrated intolerance (e.g., allergy, hypersensitivity, adverse effect(s), development of a contraindication) from at least one systemic DMARD medication (acitretin, methotrexate, cyclosporine) AND at least one topical antipsoriasis medication (e.g., corticosteroid, Dovonex®, Tazorac®, anthralin) over a period of 30 or more days for each drug?
 Yes No

Medical justification: (Attach additional page if necessary): _____

Prescriber's signature: _____ Date: _____