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

TODAY'S HEALTH

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.

Prior Authorization Request Form

TODAY'S HEALTH

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

1 Please indicate Enbrel®'s dispensing location:
- ☐ the physician's supply, incident to a physician's visit
- ☐ the pharmacy
- ☐ other: ....

2 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)

3 Is the prescribing physician a rheumatologist or dermatologist or has one been consulted?
☐ Yes ☐ No

4 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

5 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

6 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): ______________________

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Prescriber's signature:______________________ Date:______________________