

## ENBREL (etanercept) (preferred) PRIOR AUTHORIZATION FORM

Cytokine and CAM Antagonists and Quantity Limits/Daily Dose Limits prior authorization guidelines are accessible on the Department's Pharmacy Services website at <http://www.dhs.pa.gov/provider/pharmacyservices/index.htm>.

PRIOR AUTHORIZATION REQUEST INFORMATION			PRESCRIBER INFORMATION		
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	Total # of pages: _____	Prescriber name: _____		
<input type="checkbox"/> Renewal request	(PA#: _____)		Specialty: _____		
Name of office contact: _____			State license #: _____		
Contact's phone number: _____			NPI: _____		
LTC facility contact/phone: _____			MA Provider ID#: _____		
RECIPIENT INFORMATION			Street address: _____		
Recipient Name: _____			Suite #: _____	City/state/zip: _____	
Recipient ID#: _____	DOB: _____	Phone: _____	Fax: _____		

### CLINICAL INFORMATION

<b>Product requested:</b>	<input type="checkbox"/> Enbrel 25 mg/0.5 ml syringe	<input type="checkbox"/> Enbrel 50 mg/ml syringe
	<input type="checkbox"/> Enbrel 25 mg vial kit	<input type="checkbox"/> Enbrel 50 mg/ml SureClick pen
Directions: _____	Quantity: _____	Refills: _____
Diagnosis ( <i>submit documentation</i> ): _____		Recipient's weight: _____ lbs/kg
Diagnosis ( <i>submit documentation</i> ): _____		Diagnosis code ( <i>required</i> ): _____

### ALL requests

1. **Specialty Pharmacy Drug Program:** What Specialty Pharmacy will be used?  Diplomat Specialty  Walgreens Specialty
2. Check all that apply to the Recipient and *submit documentation for each*.
 

<input type="checkbox"/> screened for hepatitis B (antibody and/or surface antigen)	<input type="checkbox"/> up-to-date with all age-appropriate immunizations (if < 21 years of age, in accordance with EPSDT guidelines)
<input type="checkbox"/> screened for tuberculosis	

### INITIAL requests – complete questions applicable to Recipient's diagnosis

1. **Ankylosing spondylitis or psoriatic arthritis:** Does the Recipient have a history of trial and failure, contraindication, or intolerance of the following?
 

<input type="checkbox"/> four-week trial each of at least 2 different NSAIDs	<input type="checkbox"/> Yes <i>Submit documentation of all medications tried and outcomes.</i>
<input type="checkbox"/> eight-week trial of methotrexate or other DMARD ( <i>does not apply to axial disease</i> )	<input type="checkbox"/> No <i>Submit documentation of all medications tried and outcomes.</i>
2. **Rheumatoid arthritis:** Does the Recipient have a history of trial and failure, contraindication, or intolerance of at least 3 months of treatment with methotrexate or another DMARD?
 

<input type="checkbox"/> Yes <i>Submit documentation of all medications tried and outcomes.</i>
<input type="checkbox"/> No <i>Submit documentation of all medications tried and outcomes.</i>
3. **Plaque psoriasis:** Does at least one of the following apply to the Recipient?
 

<input type="checkbox"/> at least 5% of body surface area (BSA) is affected	<input type="checkbox"/> Yes <i>Submit documentation.</i>
<input type="checkbox"/> critical areas of the body are involved (face, palms, soles, and/or genitals)	<input type="checkbox"/> No <i>Submit documentation.</i>
4. **Plaque psoriasis:** Does the Recipient have a history of trial and failure, contraindication, or intolerance of a 3-month trial of the following treatments? *Check all that apply.*

<input type="checkbox"/> PUVA <input type="checkbox"/> UVB light	<input type="checkbox"/> Yes <i>Submit documentation treatments tried and outcomes.</i>
	<input type="checkbox"/> No <i>Submit documentation treatments tried and outcomes.</i>
5. **Plaque psoriasis:** Does the Recipient have a history of trial and failure, contraindication, or intolerance of the following medications? *Check all that apply.*

<input type="checkbox"/> acitretin <input type="checkbox"/> cyclosporine <input type="checkbox"/> methotrexate	<input type="checkbox"/> Yes <i>Submit documentation of all medications tried and outcomes.</i>
	<input type="checkbox"/> No <i>Submit documentation of all medications tried and outcomes.</i>
6. **Juvenile idiopathic arthritis:** Submit form to Pharmacy Services with documentation supporting Recipient's diagnosis.
7. **All other diagnoses:** Submit documentation supporting the use of the requested medication for the Recipient's diagnosis and all treatment regimens tried.

### RENEWAL requests

1. Since starting Enbrel, has the Recipient experienced a positive clinical response and/or improved level of functioning?
 

<input type="checkbox"/> Yes <i>Submit documentation of clinical response.</i>
<input type="checkbox"/> No <i>Submit documentation of clinical response.</i>

**PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION**

Prescriber Signature: _____	Date: _____
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