pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

ENBREL (etanercept) [non-preferred] PRIOR AUTHORIZATION FORM (*Form effective 1/28/19*)

Cytokine and CAM Antagonists and **Quantity Limits/Daily Dose Limits** prior authorization guidelines: http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	# of pages: ________	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Product requested:
☐Enbrel 25 mg/0.5 ml syringe ☐Enbrel 50 mg/ml syringe ☐Enbrel 50 mg/ml mini cartridge
☐Enbrel 25 mg vial kit ☐Enbrel 50 mg/ml SureClick pen ☐Enbrel: ____________________

Directions:	Quantity:	Refills:	Beneficiary's weight: _______ lbs/kg

Diagnosis (*submit documentation*):	Diagnosis code (*required*):

Specialty Pharmacy Drug Program: Which specialty pharmacy will be used? ☐Diplomat Specialty ☐Walgreen's Specialty

INITIAL requests – complete questions applicable to beneficiary's diagnosis

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

Question	Answer	Documentation
2. ***Rheumatoid arthritis:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of at least 3 months of treatment with methotrexate or another DMARD?	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
3. ***Rheumatoid arthritis***: Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred agents? *Check all that apply.* ☐Humira ☐Xeljanz	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
4. ***Ankylosing spondylitis and adult plaque psoriasis***: Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred agents? *Check all that apply.* ☐Cosentyx ☐Humira	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
5. ***Psoriatic arthritis***: Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred agents? *Check all that apply.* ☐Cosentyx ☐Humira ☐Xeljanz	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
6. ***Ankylosing spondylitis or psoriatic arthritis***: Does the beneficiary 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 ☐No	*Submit documentation of all medications tried and outcomes.*
7. ***ADULT plaque psoriasis:*** Does at least one of the following apply to the beneficiary? ☐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.*
8. ***ADULT plaque psoriasis:*** Does the beneficiary 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.*
9. ***Juvenile idiopathic arthritis:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred agent, **Humira**?	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*

10. ***PEDIATRIC plaque psoriasis:*** Submit form to Pharmacy Services with documentation supporting the diagnosis.

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

RENEWAL requests

Question	Answer	Documentation
1. Since starting Enbrel, did the beneficiary 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 TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**:

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