

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#: _____)	_____		
Name of office contact:			Specialty:	
Contact's phone number:			State license #:	
LTC facility contact/phone:			NPI:	MA Provider ID#:
RECIPIENT INFORMATION			Street address:	
Recipient Name:			Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:	

CLINICAL INFORMATION

Product requested:	<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:
		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? <input type="checkbox"/> Diplomat Specialty <input type="checkbox"/> Walgreens Specialty
2. Check all that apply to the Recipient and <i>submit documentation for each</i> .
<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

3. Ankylosing spondylitis or psoriatic arthritis: Does the Recipient have a history of trial and failure, contraindication, or intolerance of the following? <input type="checkbox"/> six-week trial each of at least 2 different NSAIDs <input type="checkbox"/> three-month trial of methotrexate or other DMARD	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation of all medications tried and outcomes.</i>
4. Rheumatoid arthritis or juvenile idiopathic arthritis: Does the Recipient have a history of trial and failure, contraindication, or intolerance of <u>at least 3 months of</u> treatment with methotrexate or another DMARD?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation of all medications tried and outcomes.</i>
5. Plaque psoriasis: Does at least one of the following apply to the Recipient? <input type="checkbox"/> at least 10% of body surface area (BSA) is affected <input type="checkbox"/> critical areas of the body are involved (face, palms, soles, and/or genitals)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation.</i>
6. Plaque psoriasis: Does the Recipient have a history of trial and failure, contraindication, or intolerance of a 3-month trial of the following treatments? <i>Check all that apply.</i> <input type="checkbox"/> PUVA <input type="checkbox"/> UVB light with either coal tar or dithranol	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation treatments tried and outcomes.</i>
7. Plaque psoriasis: Does the Recipient have a history of trial and failure, contraindication, or intolerance of the following medications? <i>Check all that apply.</i> <input type="checkbox"/> acitretin <input type="checkbox"/> cyclosporine <input type="checkbox"/> methotrexate	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation of all medications tried and outcomes.</i>

All other diagnoses: Submit documentation supporting the use of the requested medication for the Recipient's diagnosis.

RENEWAL requests

1. Since starting Enbrel, has the Recipient experienced a positive clinical response and/or improved level of functioning?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation of clinical response.</i>
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PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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