

# Pharmacy Prior Authorization Form

Last Reviewed: Mar. 08

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to:  Commercial Plan\*  Medicaid Plan  Medicare Plan

## Enbrel™ (etanercept)

\*This medication must be dispensed at a participating Specialty Pharmacy (not applicable to Medicaid or Medicare)

Member Name: \_\_\_\_\_ Member #: \_\_\_\_\_ - \_\_\_\_\_

DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ Provider Phone: \_\_\_\_\_

Provider Name: \_\_\_\_\_ Provider Fax: \_\_\_\_\_

Provider Office Contact Name: \_\_\_\_\_ Date: \_\_\_\_\_

### Dose: (Please choose one)

 25mg Twice Weekly  50mg Once Weekly  50mg Twice Weekly\*

\*Please note: Doses of 50mg twice weekly are only considered for treatment of plaque psoriasis for up to 3 months.

### FDA approved indications:

**Rheumatoid Arthritis** – Reduction in the signs and symptoms of moderately to severely active rheumatoid arthritis in patients who have had an inadequate response to one or more disease modifying antirheumatic drugs.

**Polyarticular-Course Juvenile Rheumatoid Arthritis** – Reduction in the signs and symptoms of moderately to severely active polyarticular-course juvenile rheumatoid arthritis in patients who have had an inadequate response to one or more disease modifying antirheumatic drugs.

**Psoriatic Arthritis** – Reduction in the signs and symptoms and inhibiting the progression of active arthritis in patients with psoriatic arthritis.

**Ankylosing Spondylitis** – Reduction in the signs and symptoms in patients with active ankylosing spondylitis.

**Plaque Psoriasis** – Treatment of adult patients (18 years or older) with chronic moderate to severe plaque psoriasis who are candidates for systemic therapy or phototherapy.

### Authorization is for a (check which applies):

 Continuation/Refill request (complete Section 1 below)  New request (complete Section 2 below)

### Priority Health precertification requirements:

#### Section 1: Continuation/Refill request (All of the following must apply for continued authorization)

- The patient is compliant in taking the medication as scheduled
- The patient tolerated the medication
- The patient did not experience any severe adverse reactions while taking the medication
- The patient has responded to treatment, as determined by the prescribing physician
- The patient has a negative TB test result. Date: \_\_\_\_\_ (must be done yearly)

#### Section 2: New request (Check which applies)

##### 1. Diagnosis of moderate to severe rheumatoid arthritis in adults (all of the following are required)

- Patient has a negative TB test result. Date: \_\_\_\_\_ (must be done yearly)
- Treatment failure with one or more DMARD (see table 2 below)

Drug: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Drug: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Drug: \_\_\_\_\_ Trial dates: \_\_\_\_\_

2.  **Diagnosis of moderate to severely active polyarticular-course juvenile rheumatoid arthritis** (all of the following are required):

Patient has a negative TB test result. Date: \_\_\_\_\_ (*must be done yearly*)

Treatment failure with one or more DMARD (see table 2 below)

Drug: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Drug: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Drug: \_\_\_\_\_ Trial dates: \_\_\_\_\_

3.  **Diagnosis of active ankylosing spondylitis** (all of the following are required):

Patient has a negative TB test result. Date: \_\_\_\_\_ (*must be done yearly*)

Presence of active disease for at least 4 weeks as defined by a sustained BASDAI of at least 4 and an expert opinion based on clinical features, acute phase reactants, and imaging modalities.

Presence of refractory disease defined by failure of at least two NSAIDs during a single 3-month period.

NSAID: \_\_\_\_\_ Trial dates: \_\_\_\_\_

NSAID: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Failure of intra-articular steroids:

Drug: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Failure of sulfasalazine in patients with peripheral arthritis

4.  **Diagnosis of chronic moderate to severe plaque psoriasis** (all of the following are required):

Patient has a negative TB test result. Date: \_\_\_\_\_ (*must be done yearly*)

Plaque psoriasis affects > 10% Body Surface Area (unless affects hands, feet, head and neck, or genitalia)  
Does plaque psoriasis affect hands, feet, head and neck, or genitalia?  yes  no

Documented therapeutic trial and clinical failure of one or more topical agents:

Drug: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Drug: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Documented therapeutic trial and clinical failure with phototherapy (UVA, UVB)

Type of therapy: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Documented therapeutic trial and clinical failure with one or more oral systemic treatments, unless contraindicated (ex: azathioprine, Neoral, methotrexate, cyclosporine, Soriatane)

Drug: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Drug: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Drug: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Does the patient have a contraindication to systemic treatment?  yes  no

List contraindication: \_\_\_\_\_

**5.  Diagnosis of psoriatic arthritis** (all of the following are required):

Patient has a negative TB test result. Date: \_\_\_\_\_ *(must be done yearly)*

Treatment failure with one or more DMARD (see table 1 below)

Drug: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Drug: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Drug: \_\_\_\_\_ Trial dates: \_\_\_\_\_

**Note: Approval, when granted, will be for a 30 day supply per fill at the dose and duration outlined below in table 1.**

**TABLE 1. Dose and Duration of Authorization**

Indication	Initial Authorization	Continuation Authorization
Adult rheumatoid arthritis	<ul style="list-style-type: none"> <li>Approved for 3 months</li> <li>Approved dose is 50mg SQ weekly or 25mg BIW</li> </ul>	<ul style="list-style-type: none"> <li>Approved for an additional 12 months if the patient has responded, as determined by the prescribing physician</li> <li>Approved dose is 50mg SQ weekly or 25mg BIW</li> </ul>
Juvenile rheumatoid arthritis	<ul style="list-style-type: none"> <li>Approved for 3 months</li> <li>Approved dose is 50mg SQ weekly, 25mg BIW, 25mg weekly, or 50mg every 10 days</li> </ul>	<ul style="list-style-type: none"> <li>Approved for an additional 12 months if the patient has responded, as determined by the prescribing physician</li> <li>Approved dose is 50mg SQ weekly, 25mg BIW, 25mg weekly, or 50mg every 10 days</li> </ul>
Ankylosing spondylitis	<ul style="list-style-type: none"> <li>Approved for 3 months</li> <li>Approved dose is 50mg SQ weekly or 25mg BIW</li> </ul>	<ul style="list-style-type: none"> <li>Approved for an additional 12 months if the patient has responded, as determined by the prescribing physician</li> <li>Approved dose is 50mg SQ weekly or 25mg BIW</li> </ul>
Plaque psoriasis	<ul style="list-style-type: none"> <li>Approved for 3 months</li> <li>Approved dose is 50mg SQ BIW (total 100mg/week)</li> </ul>	<ul style="list-style-type: none"> <li>Approve for an additional 3 months of therapy if the patient has responded, as determined by the prescribing physician</li> <li>Approved dose is 25mg BIW</li> <li>If Enbrel proves to be effective for the patient, then they may receive additional therapy courses beyond 6 months upon disease recurrence</li> </ul>
Psoriatic arthritis	<ul style="list-style-type: none"> <li>Approved for 3 months</li> <li>Approved dose is 50mg SQ weekly or 25mg BIW</li> </ul>	<ul style="list-style-type: none"> <li>Approved for an additional 12 months if the patient has responded, as determined by the prescribing physician</li> <li>Approved dose is 50mg SQ weekly or 25mg BIW</li> </ul>

