

Pharmacy Prior Authorization Form

Last Reviewed: Sept. 11

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)

Non-Urgent Urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:

- Enbrel 25 mg single-use prefilled syringe
- Enbrel 50 mg single-use prefilled syringe
- Enbrel 50 mg single-use prefilled SureClick[™] autoinjector

Dose: _____ Start date: _____

Prescriber is a rheumatologist:

- Yes
- No

Priority Health Precertification Requirements:

Authorization of Enbrel requires:

- One of the following diagnoses:
 1. Rheumatoid arthritis
 - Documented therapeutic trial of at least one DMARD
 2. Juvenile rheumatoid arthritis
 - Documented therapeutic trial of at least one DMARD
 3. Psoriatic arthritis
 - Documented therapeutic trial of at least one DMARD
 4. Ankylosing spondylitis
 - Presence of active disease of at least 4 weeks
 - BASDAI score of at least 4
 - Documented therapeutic trial and failure of at least two NSAIDs during a single 3-month period
 - Documented therapeutic trial of intra-articular steroids
 - Documented therapeutic trial of sulfasalazine
 5. Moderate to severe plaque psoriasis
 - Involvement of greater than 10% of body surface area (unless hands, feet, head, neck, or genitalia are involved)
 - Documented therapeutic trial of one or more topical agents
 - Documented therapeutic trial of phototherapy
 - Documented therapeutic trial of one or more systemic treatments
- Negative TB test (must be done yearly)
- Patient must **not** have moderate to severe heart failure

Continuation of Enbrel therapy requires:

- Patient must be compliant taking the medication as prescribed

- Patient must be tolerating the medication
- Patient must not be experiencing any severe adverse reactions while taking the medication
- Patient must be responding positively to the medication
- Patient must have a negative TB test within the past 12 months

Diagnosis:

- Rheumatoid Arthritis
- Juvenile Rheumatoid Arthritis
- Psoriatic Arthritis
- Ankylosing Spondylitis
- Plaque psoriasis
- Other: _____ Please provide rationale for use:

Results of annual (within the past 12 months) TB test:

- Positive - Rationale for use: _____
- Negative
- Test not done – Rationale for use: _____

Patient has moderate to severe heart failure:

- Yes – Rationale for use: _____
- No

New request or continuation of therapy:

- New (see section 1)
- Continuation (see section 2)

Section 1 – New requests:

Rheumatoid Arthritis, Juvenile Rheumatoid Arthritis, or Psoriatic Arthritis

Patient has had a therapeutic trial of at least one of the following DMARDs:

- Yes
- No – Rationale for use: _____

	Dose	Dates	Outcome
<input type="checkbox"/> azathioprine	_____	_____	_____
<input type="checkbox"/> Cyclosporine	_____	_____	_____
<input type="checkbox"/> d-penicillamine	_____	_____	_____
<input type="checkbox"/> gold sodium thiomalate	_____	_____	_____
<input type="checkbox"/> auranofin	_____	_____	_____
<input type="checkbox"/> aurothioglucose	_____	_____	_____
<input type="checkbox"/> hydroxychloroquine	_____	_____	_____
<input type="checkbox"/> leflunomide	_____	_____	_____
<input type="checkbox"/> methotrexate	_____	_____	_____
<input type="checkbox"/> sulfasalazine	_____	_____	_____

Ankylosing Spondylitis

Patient has shown presence of active disease for at least 4 weeks:

- Yes
 No – Rationale for use: _____

Patient has had a sustained BASDAI score of at least 4: BASDAI score: _____

- Yes
 No – Rationale for use: _____

Patient has had a therapeutic trial of at least two NSAIDs during a single 3-month period:

- Yes
 No – Rationale for use: _____

NSAID: _____ Dose: _____ Trial dates: _____

NSAID: _____ Dose: _____ Trial dates: _____

Patient has had a therapeutic trial of intra-articular steroids and sulfasalazine:

- Yes
 No – Rationale for use: _____

Drug: _____ Dose: _____ Trial dates: _____

Drug: _____ Dose: _____ Trial dates: _____

Plaque Psoriasis

Plaque affects > 10% of the patient's body surface area:

- Yes
 No

Plaque psoriasis affects the hand, feet, head, neck, or genitalia:

- Yes
 No

Patient has had a documented trial and clinical failure of one or more topical agents:

- Yes
 No – Rationale for use: _____

Drug: _____ Dose: _____ Trial dates: _____

Drug: _____ Dose: _____ Trial dates: _____

Patient has had a documented trial and clinical failure with phototherapy (UVA, UVB):

- Yes
 No – Rationale for use: _____

Type of therapy: _____ Trial dates: _____

Patient has had a documented trial and clinical failure of one or more systemic treatments (azathioprine, Neoral, methotrexate, cyclosporine, Soriatane):

- Yes
 No – Rationale for use: _____

Drug: _____ Dose: _____ Trial dates: _____

Drug: _____ Dose: _____ Trial dates: _____

Patient has a contraindication to systemic treatments:

- Yes
 No

List the contraindication: _____

Section 2 – Requests for continuation of therapy:

- 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 had a negative TB test result within the past 12 months- Date of test: _____

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"> Approved for 3 months Approved dose is 50mg SQ weekly or 25mg twice weekly 	<ul style="list-style-type: none"> Approved for an additional 12 months if the patient has responded, as determined by the prescribing physician Approved dose is 50mg SQ weekly or 25mg twice weekly
Juvenile rheumatoid arthritis	<ul style="list-style-type: none"> Approved for 3 months Approved dose is 50mg SQ weekly, 25mg twice weekly, 25mg weekly, or 50mg every 10 days 	<ul style="list-style-type: none"> Approved for an additional 12 months if the patient has responded, as determined by the prescribing physician Approved dose is 50mg SQ weekly, 25mg twice weekly, 25mg weekly, or 50mg every 10 days
Ankylosing spondylitis	<ul style="list-style-type: none"> Approved for 3 months Approved dose is 50mg SQ weekly or 25mg twice weekly 	<ul style="list-style-type: none"> Approved for an additional 12 months if the patient has responded, as determined by the prescribing physician Approved dose is 50mg SQ weekly or 25mg twice weekly
Plaque psoriasis	<ul style="list-style-type: none"> Approved for 9 months Approved dose is 50mg SQ twice weekly (total 100mg/week) 	<ul style="list-style-type: none"> Approved for an additional 12 months if the patient has responded, as determined by the prescribing physician Approved dose is 50mg SQ weekly or 25mg twice weekly Reinitiating 50mg SQ twice weekly dosing for 3 months requires patient to meet criteria outlined below, followed by step-down to weekly dosing
Psoriatic arthritis	<ul style="list-style-type: none"> Approved for 3 months Approved dose is 50mg SQ weekly or 25mg twice weekly 	<ul style="list-style-type: none"> Approved for an additional 12 months if the patient has responded, as determined by the prescribing physician Approved dose is 50mg SQ weekly or 25mg twice weekly

For plaque psoriasis (reinitiating 50mg twice weekly therapy for 3 months):

Authorization for reinitiating 50mg twice weekly after dosage reduction requires one of the following:

- A Physician's static global assessment (PGA) of psoriasis response of 0 at month 3 with increase of ≥ 2 points after 24 weeks at 50mg weekly
- A Physician's static global assessment (PGA) of psoriasis response of 1 to 4 at month 3 with increase of ≥ 1 point after 24 weeks at 50mg weekly
- Plaque psoriasis on $\leq 10\%$ BSA at month 3 with increase of absolute BSA $\geq 2\%$ after month 3
- Plaque psoriasis on $> 10\%$ BSA at month 3 with increase of $\geq 20\%$ BSA after 3 months

FOR MEDICARE ONLY

If none of the above precertification criteria is applicable to this member, please check off which, if any, of the following apply:

1. All covered Part D drugs on any tier of a plan's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects
2. The number of doses available under a dose restriction for the prescription drug:
 - a. Has been ineffective in the treatment of the enrollee's disease or medical condition, or
 - b. Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
3. The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements:
 - a. Has been ineffective in the treatment of the enrollee's disease or medical condition, or
 - b. Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
 - c. Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.
4. None of the above apply

****If you selected 1, 2, or 3 above, supporting evidence/documentation is required for review. If no supporting evidence/documentation is provided, this request will not be approved.**

***** All fields must be complete and legible for Prior Authorization Review*****

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX