PriorityHealth

Pharmacy Prior Authorization Form

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

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)
Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Enbrel® (etanercept)

Member

Last Name: ________________ First Name: ________________
ID #: ________________ DOB: ________________ Gender: ________________
Primary Care Physician: ________________

Requesting Provider: ________________ Prov. Phone: ________________ Prov. Fax: ________________
Provider Address: ________________
Provider NPI: ________________ Contact Name: ________________

Provider Signature: ________________ Date: ________________

Product Information

☐ New Request ☐ Continuation Request

Drug product:
☐ Enbrel 25 mg prefilled syringe
☐ Enbrel 50 mg prefilled syringe
☐ Enbrel 50 mg SureClick™ autoinjector

Start date (or date of next dose): ________________
Date of last dose (if applicable): ________________
Dosing frequency: ________________

ENBREL COVERAGE POLICY

- Before Enbrel is covered, the patient must meet all of the General Criteria for Enbrel and all of the Specific Criteria for the treatment diagnosis. If these criteria are not met, the prescriber must provide an explanation of why an exception to the criteria is necessary.
- Coverage for a diagnosis not listed below will be considered on a case by case basis. Please provide rationale for use and all pertinent patient information.
- Enbrel will not be covered in combination with another biologic drug.
- Please provide rationale when requesting any dose or dosing interval not listed in the FDA label.

Criteria

General Initiation Criteria for ALL Diagnoses:

a) Patient has evidence of a negative TB test result in the past 12 months (or TB is adequately managed); AND
b) Patient does not have moderate to severe heart failure (or heart failure is adequately managed); AND
c) Prescriber is a specialist or has consulted with a specialist for the condition being treated.

Specific Initiation Criteria for Individual Diagnoses:

1. Ankylosing Spondylitis
   There are no Specific Initiation Criteria for this indication. Enbrel is covered for any patient who meets the above General Initiation Criteria.

2. Juvenile Idiopathic Arthritis
   a) Patient has tried at least ONE other agent for this condition (e.g., methotrexate, sulfasalazine, leflunomide, nonsteroidal anti-inflammatory drug, a biologic [Humira, Orencia, Enbrel, Kineret, Actemra]) for a period of at least 3 months; OR
   b) Patient will be starting on Enbrel concurrently with methotrexate, sulfasalazine, or leflunomide; OR
   c) Patient has aggressive disease, as determined by the prescribing physician.

All fields must be complete and legible for review. Your office will receive a response via fax.

3. Plaque Psoriasis
   a) Patient has tried **ALL** of the following for a period of at least 3 months:
      a. One topical agent
      b. One non-biologic systemic agent (e.g., methotrexate [MTX], cyclosporine, acitretin)
      c. Phototherapy
      d. Humira (note: patients under 18 years of age are not required to first try Humira)

4. Psoriatic Arthritis
   a) Patient has tried at least ONE conventional systemic DMARD (such as methotrexate, leflunomide, sulfasalazine, or azathioprine) for a period of at least 3 months.

5. Rheumatoid Arthritis
   a) Patient has tried at least ONE conventional systemic DMARD (such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine) for a period of at least 3 months.

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Ankylosing spondylitis
☐ Juvenile idiopathic arthritis
☐ Plaque psoriasis
☐ Psoriatic arthritis
☐ Rheumatoid arthritis
☐ Other – the patient's condition is: ____________________
Rationale for use: ____________________

B. Which of the following has the patient had a documented therapeutic trial with?

☐ NSAID Dates of therapy: ____________________
☐ Methotrexate Dates of therapy: ____________________
☐ Leflunomide Dates of therapy: ____________________
☐ Hydroxychloroquine Dates of therapy: ____________________
☐ Sulfasalazine Dates of therapy: ____________________
☐ Cyclosporine Dates of therapy: ____________________
☐ Acitretin Dates of therapy: ____________________
☐ Actemra Dates of therapy: ____________________
☐ Cosentyx Dates of therapy: ____________________
☐ Humira Dates of therapy: ____________________
☐ Kineret Dates of therapy: ____________________
☐ Orencia Dates of therapy: ____________________
☐ Stelara Dates of therapy: ____________________
☐ Xeljanz Dates of therapy: ____________________
☐ Other Drug: ____________ Dates of therapy: ____________________

C. Has the patient had a negative TB test result in the past 12 months?

☐ Yes Date: ____________
☐ No, rationale for use: ____________________

D. Does the patient have moderate to severe heart failure?

☐ Yes Date: ____________
☐ No, rationale for use: ____________________

E. Will the patient be receiving other biologic therapy in combination with Enbrel?

☐ No ☐ Yes, rationale for use: ____________________

<u>The following questions are required for **plaque psoriasis** only:</u>

F. Has the patient had a trial with one or more topical agents for a period of at least 3 months?

- ☐ Yes
- ☐ No – rationale for use: ______________________________

G. Has the patient had a trial with phototherapy for a period of at least 3 months?

- ☐ Yes, UVA
- ☐ Yes, UVB
- ☐ No – rationale for use: ______________________________

H. Has the patient had a trial with one or more non-biologic systemic agents for a period of at least 3 months?

- ☐ No – rationale for use: ______________________________
- ☐ Yes – Please mark the agent(s) tried and failed above.

I. Has the patient had a trial with Humira for a period of at least 3 months?

- ☐ No – rationale for use: ______________________________
- ☐ Yes

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