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.
- 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.

Initiation 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)

b) Prescriber is a rheumatologist or dermatologist or has consulted with a specialist for the condition

Specific Initiation Criteria for Individual Diagnoses:

1. Ankylosing Spondylitis
   - **a)** Trial and failure of 2 different NSAIDs within the last 60 days; AND
   - **b)** Trial and failure of sulfasalazine.

2. Juvenile Idiopathic Arthritis
   - **a)** Trial and failure of methotrexate for at least 3 consecutive months or contraindication/intolerance to methotrexate; AND
   - **b)** Patient is at least 2 years old.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 09/2018

Last reviewed 09/2018

3. Plaque Psoriasis
   - **a)** Involvement of greater than 15% of body surface area (unless hands, feet, head, neck or genitalia are involved); AND
   - **b)** Trial and failure of at least one topical agent; AND
   - **c)** Trial and failure of UVB or PUVA therapy or contraindication to therapy; AND
   - **d)** Trial and failure of methotrexate for at least 3 consecutive months or contraindication/intolerance to methotrexate; AND
   - **e)** Trial and failure or contraindication of at least one other systemic treatment (azathioprine, cyclosporine).
4. Psoriatic Arthritis
   - **a)** Trial and failure of methotrexate for at least 3 consecutive months; AND
   - **b)** Trial and failure of one additional DMARD [such as sulfasalazine, leflunomide, or cyclosporine].

5. Rheumatoid Arthritis
   - **a)** Trial and failure of methotrexate for at least 3 consecutive months; AND
   - **b)** Trial and failure of one additional oral DMARD (such as leflunomide, hydroxychloroquine, or sulfasalazine) as sequential monotherapy for 3 months OR in combination with methotrexate for at least 3 months unless contraindication.

Continuation Criteria

For continuation, patient must have met the following requirements:

1. Must be compliant with therapy
2. Must have a response to therapy

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.

Initial Request
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, drug name and dates of therapy: _____
- ☐ NSAID, drug name and 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: _____
- ☐ PUVA or UVB Dates of therapy: _____
- ☐ Topical agent, drug name and dates of therapy:

  _____
- ☐ Other Drug: _____ Dates of therapy: _____

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

☐ Yes Date: _____

☐ No, rationale for use: _____

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

☐ No ☐ Yes, rationale for use: _____

Continuation Request
Priority Health Precertification Documentation

1. Is there documentation that the patient has been compliant on therapy (e.g., claims history, chart notes)?

☐ Yes

☐ No, rationale for use: _____

2. Is there documentation that the patient has responded to therapy?

☐ Yes

☐ No, rationale for use: _____

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