PriorityHealth

Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**
This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

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: __________ ☐ Rheumatologist

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: ____________________

Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

For this drug to be covered, the patient must meet the following criteria:

1. Must be used for a medically-accepted indication*
   - For rheumatoid arthritis
     i. Must try one non-biologic DMARD
   - For juvenile rheumatoid arthritis
     i. Must try one non-biologic DMARD
   - For psoriatic arthritis
     i. Must try one non-biologic DMARD
   - For ankylosing spondylitis
     i. Must try one NSAID
     ii. Must have a BASDAI score of at least 4
     iii. Must have presence of active disease for at least 4 weeks
   - For moderate to severe plaque psoriasis
     i. Must have > 5% body surface area affected (unless hands, feet, head, neck, or genitalia involved)
     ii. Must try one of the following: cyclosporine, methotrexate, methylprednisolone, prednisone, Soriatane
2. Must have a negative TB test (must be done yearly)

Additional information

Note: When criteria are met, duration of approval will be 1 year

Medically-accepted indication*

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Rheumatoid arthritis (moderate to severe)
☐ Juvenile rheumatoid arthritis (moderate to severe)
☐ Psoriatic arthritis
☐ Ankylosing spondylitis
☐ Chronic plaque psoriasis (moderate to severe)
☐ *Other – the patient's condition is:* ____________________
Rationale for Other use: ____________________

B. What is the date and result of the patient's most recent TB test?

☐ Negative **Date:** ____________________
☐ Positive
☐ Not completed. **Are you requesting an exception to the criteria?**
☐ Yes. ***Rationale for exception***: ____________________
☐ No

Complete the required sections below, based on diagnosis.

Rheumatoid Arthritis, Juvenile Rheumatoid Arthritis, or Psoriatic Arthritis

A. Has the patient tried one non-biologic DMARD?

☐ Yes

	Dose	Dates	Outcome
☐ azathioprine			
☐ cyclosporine			
☐ hydroxychloroquine			
☐ leflunomide			
☐ methotrexate			
☐ sulfasalazine			

☐ No. **Are you requesting an exception to the criteria?**
☐ Yes. ***Rationale for exception***: ____________________
☐ No

Ankylosing Spondylitis

A. Has the patient shown presence of active disease for at least 4 weeks?

☐ Yes
☐ No. **Are you requesting an exception to the criteria?**
☐ Yes. ***Rationale for exception***: ____________________
☐ No

B. Does the patient have a BASDAI score of at least 4?

☐ Yes
☐ No. **Are you requesting an exception to the criteria?**
☐ Yes. ***Rationale for exception***: ____________________
☐ No

C. Has the patient tried at least one NSAID?

- ☐ Yes
- ☐ No. **Are you requesting an exception to the criteria?**
  - ☐ Yes. ***Rationale for exception***: ______________________
  - ☐ No

Moderate to severe plaque psoriasis

A. Does the patient's psoriasis affect one of the following?

- ☐ more than 5% body surface area
- ☐ hands
- ☐ genitalia
- ☐ feet
- ☐ neck
- ☐ head

- ☐ None. **Are you requesting an exception to the criteria?**
  - ☐ Yes. ***Rationale for exception***: ______________________
  - ☐ No

B. Has the patient tried one of the following drugs?

- ☐ Yes. Select all that apply:
  - ☐ prednisone
  - ☐ methotrexate
  - ☐ Soriatane
  - ☐ cyclosporine
  - ☐ methylprednisolone
  - ☐ Other: ______________

- ☐ No. **Are you requesting an exception to the criteria?**
  - ☐ Yes. ***Rationale for exception***: ______________________
  - ☐ No

Priority Health Medicare Exception Request *(exceptions to the above criteria)*

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Enbrel likely be the most effective option for this patient?
☐ Yes ☐ No
If yes, please explain why: ______________________

____

____

If the patient is currently using Enbrel, would changing the patient's current regimen likely result in adverse effects for the patient?
☐ Yes ☐ No
If yes, please explain: ______________________

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All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 01/2019
Last reviewed 01/2019