FUTURE SCRIPTS

Please complete ALL information below and fax your request to 1-888-671-5285

Enbrel® Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

- ❑ Ankylosing spondylitis (for example: M45.0, M45.9)
- ❑ Plaque psoriasis (for example: psoriasis vulgaris, psoriasis; L40.0, L40.8, L40.9)
- ❑ Polyarticular juvenile idiopathic arthritis (for example: M08.09, M08.40)
- ❑ Psoriatic arthritis (for example: arthropathic psoriasis; L40.5, L40.59)
- ❑ Rheumatoid arthritis (for example: M05.79, M06.9)
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is this request for continuation of prior Enbrel therapy? ❑ **Yes** ❑ **No**

Select if Enbrel is prescribed by or in consultation with one of the following specialists:

❑ Dermatologist ❑ Rheumatologist

For ankylosing spondylitis, also answer the following:

Does the patient have active disease? ❑ **Yes** ❑ **No**

Has the patient had trial and failure, contraindication, or intolerance to **TWO** non-steroidal anti-inflammatory drugs (NSAIDs)? ❑ **Yes** ❑ **No**

Select if the patient has had trial and failure, contraindication, or intolerance to the following, or attestation demonstrating a trial may be inappropriate:

❑ Cimzia (certolizumab pegol) ❑ Humira (adalimumab) ❑ Simponi (golimumab) or Simponi Aria (golimumab IV)

For plaque psoriasis, also answer the following:

Does the patient have moderate to severe chronic disease? ❑ **Yes** ❑ **No**

Select if the patient has had trial and failure, contraindication, or intolerance to the following:

❑ Cimzia (certolizumab pegol) ❑ Humira (adalimumab) ❑ Tremfya (guselkumab)
❑ Cosentyx (secukinumab) ❑ Skyrizi (risankizumab) ❑ Stelara (ustekinumab)

For polyarticular juvenile idiopathic arthritis, also answer the following:

Does the patient have moderately to severely active disease? ❑ **Yes** ❑ **No**

Has the patient had trial and failure, contraindication, or intolerance to **ONE** of the following non-biologic modifying anti-rheumatic drugs (DMARDs): Arava (lefunomide) **OR** Rheumatrex/Trexall (methotrexate)? ❑ **Yes** ❑ **No**

Has the patient had trial and failure, contraindication, or intolerance to Humira (adalimumab)? ❑ **Yes** ❑ **No**

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For psoriatic arthritis, also answer the following:

Does the patient have active disease? ❑ **Yes** ❑ **No**

Select if the patient has had trial and failure, contraindication, or intolerance to the following:

- ❑ Cimzia (certolizumab pegol)
- ❑ Cosentyx (secukinumab)
- ❑ Humira (adalimumab)
- ❑ Simponi (golimumab) or Simponi Aria (golimumab IV)
- ❑ Stelara (ustekinumab)
- ❑ Xeljanz (tofacitinib) or Xeljanz XR (tofacitinib ER)

For rheumatoid arthritis, also answer the following:

Does the patient have moderately to severely active disease? ❑ **Yes** ❑ **No**

Has the patient had trial and failure, contraindication, or intolerance to **ONE** non-biologic disease modifying anti-rheumatic drug (DMARD) (e.g., Rheumatrex/Trexall [methotrexate], Arava [leflunomide], Azulfidine [sulfasalazine])? ❑ **Yes** ❑ **No**

Select if the patient has had trial and failure, contraindication, or intolerance to the following, or attestation demonstrating a trial may be Inappropriate:

- ❑ Cimzia (certolizumab pegol)
- ❑ Humira (adalimumab)
- ❑ Simponi (golimumab) or Simponi Aria (golimumab IV)

Select if the patient has had trial and failure, contraindication, or intolerance to the following:

- ❑ Actemra (tocilzumab)
- ❑ Xeljanz (tofacitinib) or Xeljanz XR (tofacitinib ER)

Reauthorization:

If this is a reauthorization request, answer the following:

Is there documentation the patient has had a positive clinical response to Enbrel therapy? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.