ENBREL (ETANERCEPT) [PREFERRED] PRIOR AUTHORIZATION FORM

(form effective 1/9/2023)

AmeriHealth Caritas Pennsylvania | PERFORMRX℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-888-981-5202**, or to speak to a representative call **1-866-610-2774**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	# of pages:	Name of office contact:
Contact's phone number:		LTC facility contact/phone:

PATIENT INFORMATION

Patient name:		Patient ID #:	DOB:
Street address:	Apt. #:	City/state/zip:	

PRESCRIBER INFORMATION

Prescriber name:		Specialty:	
State license #:	NPI:	MA Provider ID #:	
Street address:	Suite #:	City/state/zip:	
Phone:	Fax:		

CLINICAL INFORMATION

Product requested:	☐ Enbrel 25 mg/0.5 ml syringe ☐ Enbrel 25 mg vial kit ☐ Enbrel 25 mg/0.5 mL vial	☐ Enbrel 50 mg/ml syringe ☐ Enbrel 50 mg/ml SureClick pen	☐ Enbrel 50 mg/ml mini cartridge ☐ Enbrel:_____
Quantity: _____	Refills: _____	Patient's weight: _____ lbs/kg	
Directions:			
Diagnosis (submit documentation):		Diagnosis code *(required)*:	

PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication):

Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Patient's Preferred Pharmacy Name:	
Pharmacy Phone #:	Pharmacy Fax #:
☐ I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.	

INITIAL REQUESTS (Complete questions applicable to patient's diagnosis):

1. ***All diagnoses***: Check all that apply to the patient.
   ☐ screened for tuberculosis ☐ screened for hepatitis B (anti-HBs, HBsAg, and anti-HBc)

2. ***All diagnoses***: Is Enbrel being prescribed by or in consultation with an appropriate specialist? ☐ Yes - list specialty _____ ☐ No

3. ***Rheumatoid arthritis:*** Does the patient have a history of trial and failure, contraindication, or intolerance of at least 3 months of treatment with methotrexate or another non-biologic DMARD?
   ☐ Yes – List medications tried:_____
   ☐ No

4. ***Psoriatic arthritis:*** Does at least one of the following apply to the patient?:
   ☐ axial disease, dactylitis, and/or enthesitis
   ☐ has tried and failed methotrexate or other DMARD for at least an 8-week trial
   List medications tried or explain contraindication: _____
   ☐ severe disease
   ☐ concomitant moderate-to-severe nail disease
   ☐ concomitant active inflammatory bowel disease

5. ***Ankylosing spondylitis***: Does the patient have a history of trial and failure of a two-week trial of continuous treatment with two different oral NSAIDs?
   ☐ Yes – list medications tried:_____
   ☐ No – provide explanation: _____

6. ***Chronic psoriasis:*** Check all that apply to the patient.
   ☐ at least 3% of body surface area (BSA) is affected
   ☐ critical areas of the body are involved (such as face, palms, soles, and/or genitals)
   ☐ significant disability or impairment of physical, mental, or psychosocial functioning
   ☐ moderate to severe nail disease
   ☐ history of therapeutic failure, contraindication or intolerance to (check all that apply):
   ☐ 4-week trial of topical steroids or 8-week trial of other topical therapy; list medications tried or explain contraindication: _____
   ☐ 3-month trial of conventional systemic therapy; list medications tried or explain contraindication: _____
   ☐ phototherapy

INITIAL REQUESTS (Complete questions applicable to patient's diagnosis):

7. ***Juvenile idiopathic arthritis (JIA):*** check all that apply to the patient.

☐ therapeutic failure of a three-month trial of a conventional non-biologic DMARD; list medications tried: _____

☐ contraindication or intolerance to non-biologic DMARDs; provide explanation: _____

☐ systemic JIA with active systemic features

☐ one or more risk factors for disease severity

☐ involvement of high-risk joints (e.g. cervical spine, hip, wrist)

☐ high disease activity

☐ is at high risk of disabling joint damage

☐ active sacroliitis and/or enthesitis and has tried and failed a two-week trial of an oral NSAID; list medications tried: _____

8. ***All other diagnoses:*** Submit documentation supporting the use of Enbrel for the patient's diagnosis and all treatment regimens tried.

RENEWAL REQUESTS

Since starting Enbrel, did the patient experience improvement in disease activity and/or level of functioning?
☐ Yes ☐ No Submit documentation of clinical response.

Is Enbrel being prescribed by or in consultation with an appropriate specialist?

☐ Yes – list specialty:_____
☐ No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: