



**MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM**

Enbrel - Medicare

Phone: 215-991-4300

Fax back to: 866-371-3239

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Member Name:	Prescriber Name:	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: <input type="checkbox"/> Medicare Advantage	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

**Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.**

<p>Q1. Is this a reauthorization request?</p> <p><input type="checkbox"/> Yes - Go to 2 <input type="checkbox"/> No - Go to 3</p>
<p>Q2. Is there confirmation of continued positive clinical response since starting Enbel?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q3. Does the patient have the diagnosis of rheumatoid arthritis?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q4. Is the patient 18 years of age or older? If YES, go to 7.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. Does the patient have the diagnosis of polyarticular juvenile idiopathic arthritis (pJIA) or psoriatic arthritis (PsA)? If YES, go to 6. If NO, go to 8.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Is the patient 2 years of age or older? If YES, go to 7.</p>

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<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. Is there documentation of inadequate response, intolerance, or contraindication to at least one conventional disease modifying antirheumatic drugs (cDMARD) (e.g., azathioprine, hydroxychloroquine, D-penicillamine, sulfasalazine, methotrexate, leflunomide)? If YES, go to 17.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Does the patient have the diagnosis of plaque psoriasis? If YES, go to 9. If NO, go to 14.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Is the patient 4 years of age or older? If YES, go to 10.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q10. Is the disease moderate to severe? If YES, go to 11. If NO, go to 12.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q11. Is there documentation of inadequate response, intolerance, or contraindication to methotrexate OR ultraviolet-B (UVB) therapy (alone or in combination with other medications) OR acitretin (requires prior authorization)? If YES, go to 17.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q12. Does the patient have limited (plaque psoriasis) disease? If YES, go to 13. If NO, go to 14.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q13. Is there documentation of inadequate response, intolerance, or contraindication to one topical steroid (high to very high potency) AND calcipotriene 0.005% cream? If YES, go to 17.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q14. Does the patient have the diagnosis of ankylosing spondylitis? If YES, go to 15.	



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<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q15. Is the patient 18 years of age or older? If YES, go to 16.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q16. Is there documentation of inadequate response, intolerance, or contraindication to at least two non-steroidal anti-inflammatory drugs (NSAIDs)? If YES, go to 17.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q17. Is Enbrel being prescribed by or in consultation with a rheumatologist or dermatologist? If YES, go to 18	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q18. Has the patient been evaluated for active or latent tuberculosis (TB) infection with a tuberculin skin test prior to the initiation of therapy? If YES, go to 19.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q19. Was the tuberculin skin test negative?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q20. Is there documentation of a treatment plan to address latent or active TB infection?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q21. Requested Duration:	
<input type="checkbox"/> 12 months	<input type="checkbox"/> Other
Q22. Additional Information:	

Prescriber Signature

Date



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