Enbrel (etanercept)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTER (if different than prescriber):	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES):			

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ **YES** (if yes, complete below) ☐ **NO**		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Ankylosing spondylitis ☐ Axial spondyloarthropathy ☐ Juvenile idiopathic arthritis ☐ Plaque psoriasis ☐ Psoriatic arthritis ☐ Rheumatoid arthritis ☐ Chronic Recurrent Multifocal Osteomyelitis(CRMO) ☐ Other diagnosis: _____ ICD-10 Code(s):	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Is patient going to be using drug in combination with a clinical trial? ☐ **Yes** ☐ **No**

Select if Enbrel is prescribed by one of the following specialists:
- □ **Dermatologist**
- □ **Rheumatologist**

Will Enbrel be used in combination with a biologic response modifier or an immunomodulator agent (such as but not limited to Kineret, Rituxan, Remicade, Orencia, Cimzia, Humira, Simponi, Actemra, Stelara, Rinvoq or Xeljanz)? □ **Yes** □ **No**

Has the patient tried and had an inadequate response to a three month trial of the biosimilar for Humira- adalimumab-aacf? □ **Yes** □ **No Please submit documentation.**

Does patient have a absolute contraindication to the biosimilar for Humira- adalimumab-aacf? □ **Yes** □ **No Please submit documentation.**

Has the patient tried and had an inadequate response to a three month trial of the biosimilar for Actemra, Tyenne(tocilizumab-aazg)? □ **Yes** □ **No Please submit documentation.**

Does patient have a absolute contraindication to the biosimilar for Actemra, Tyenne(tocilizumab-aazg)? □ **Yes** □ **No Please submit documentation.**

Has the patient tried and had an inadequate response to a 4- month trial of the biosimilar for Stelara-Otulfi(ustekinumb-aauz)? □ **Yes** □ **No Please submit documentation.**

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Does patient have a absolute contraindication to the biosimilar for Stelara-Otulfi(ustekinumb-aauz)?
□ Yes □ No Please submit documentation.

For ankylosing spondylitis/ axial spondyloarthropathy, also answer the following:
Has the patient had an adequate trial and failure of at least TWO non-steroidal anti-inflammatory agents (NSAIDs)? □ Yes □ No (Provide NSAIDs and dates of service)

Has the patient tried methotrexate? □ Yes □ No (Provide dates of service)

Has the patient tried sulfasalazine? □ Yes □ No (Provide dates of service)

For juvenile idiopathic arthritis, also answer the following:
Has the patient tried and had an inadequate response or intolerance to an oral disease modifying anti-rheumatic agent [e.g., methotrexate, azathioprine (Imuran), auranofin (Ridaura), hydroxychloroquine (Plaquenil), sulfasalazine (Azulfidine), or leflunomide (Arava)]? □ Yes □ No

Is the patient unable to take a non-biologic DMARD due to chronic liver disease (such as chronic hepatitis, fatty liver, nonalcoholic steatohepatitis/NASH, or elevated liver enzymes)? □ Yes □ No

If "no" to the above question, provide the rationale explaining why the patient cannot take the prerequisite DMARDs:
_____

For plaque psoriasis, also answer the following:
Does the patient have plaques covering 10% or more of the body surface area (BSA)? □ Yes □ No

Does the patient have plaques covering < 10% of BSA, but with involvement of palms, soles, head and neck, or genitalia which causes disruption of normal activities □ Yes □ No

Has the patient tried and had an inadequate response or intolerance to at least one of the follow ing therapies: methotrexate, cyclosporine, and/or phototherapy? □ Yes □ No

If "no" to the above question, provide the rationale explaining why the patient cannot take the prerequisite agents:
_____
_____

For psoriatic arthritis, also answer the following:

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Has the patient tried and had an inadequate response or intolerance to an oral disease modifying anti-rheumatic agent [e.g., methotrexate, azathioprine (Imuran), auranofin (Ridaura), hydroxychloroquine (Plaquenil), sulfasalazine (Azulfidine), or leflunomide (Arava)]? □ Yes □ No

Is the patient unable to take a non-biologic DMARD due to chronic liver disease (such as chronic hepatitis, fatty liver, nonalcoholic steatohepatitis/NASH, or elevated liver enzymes)? □ Yes □ No

Is the patient unable to take non-biologic DMARD because they are a male of fatherhood potential or a female of childbearing potential? □ Yes □ No

If "no" to the above question, provide the rationale explaining w hy the patient cannot take the prerequisite DMARDs:

_____

For rheumatoid arthritis, also answer the following:
Has the patient tried and had an inadequate response or intolerance to methotrexate or another oral disease modifying anti-rheumatic agent (DMARD) [e.g., azathioprine (Imuran), auranofin (Ridaura), or leflunomide (Arava)]? □ Yes □ No

Is the patient unable to take a non-biologic DMARD due to chronic liver disease such as chronic hepatitis, fatty liver, nonalcoholic steatohepatitis/NASH, or elevated enzymes? □ Yes □ No

Is the patient unable to take non-biologic DMARD because they are a male of fatherhood potential or a female of childbearing potential? □ Yes □ No

For chronic recurrent multifocal osteomyelitis(CRMO):
Has patient tried and failed at least 2 types of non-steroidal anti-inflammatory agents? □ Yes □ No Please submit documentation.

Has patient tried and failed a bisphosphonate? □ Yes □ No Please submit documentation.

Does patient have an absolute contraindication to a bisphosphonate? □ Yes □ No Please submit documentation.

Has patient tried and failed some kind of DMARD such as methotrexate or corticosteroids? □ Yes □ No Please submit documentation.

Does patient have an absolute contraindication to DMARDs? □ Yes □ No Please submit documentation.

Reauthorization:
If this is a reauthorization request, answer the following questions:
Does the patient have an active infection? □ Yes □ No

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□ **Rheumatologist**

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Does the patient continue to have a positive clinical response and remission of disease is maintained with Enbrel therapy?* □ **Yes** □ **No*Please provide documentation (e.g., chart notes) supporting a positive clinical response.**

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

_____

_____

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP-4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 877-228-7909