

Enbrel (etanercept)
Prior Authorization Request Form
 Caterpillar Prescription Drug Benefit
 Phone: 877-228-7909 Fax: 800-424-7640

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/NOFP

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:
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:	

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
<input type="checkbox"/> NEW THERAPY		<input type="checkbox"/> RENEWAL	
DURATION OF THERAPY (SPECIFIC DATES):		IF RENEWAL: DATE THERAPY INITIATED:	

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE): 	DURATION OF THERAPY (SPECIFY DATES): 	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES:		ICD-10:
<input type="checkbox"/> Ankylosing spondylitis <input type="checkbox"/> Axial spondyloarthritis <input type="checkbox"/> Juvenile idiopathic arthritis <input type="checkbox"/> Plaque psoriasis <input type="checkbox"/> Psoriatic arthritis <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____		
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.		
<p>For all diagnoses, answer the following: Will Enbrel(etanercept) be used in combination with a clinical trial? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Select if Enbrel is prescribed by one of the following specialists: <input type="checkbox"/> Dermatologist <input type="checkbox"/> Rheumatologist</p> <p>Will Enbrel be used in combination with a biologic response modifier or an immunomodulator agent (such as Kineret, Rituxan, Remicade, Orencia, Cimzia, Humira, Simponi, Actemra, or Xeljanz)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has the patient tried and had an inadequate response to a three month trial of the <u>biosimilar</u> for Humira-<u>adalimumab-aacf</u>? <input type="checkbox"/> Yes <input type="checkbox"/> No Please submit documentation.</p> <p>Does patient have a absolute contraindication to the biosimilar for Humira- adalimumab-aacf? <input type="checkbox"/> Yes <input type="checkbox"/> No Please submit documentation.</p> <p>Has the patient tried and had an inadequate response to a trial of the <u>biosimilar</u> for Actemra, <u>Tyenne</u>(tocilizumab-aazg)? <input type="checkbox"/> Yes <input type="checkbox"/> No Please submit documentation.</p> <p>Does patient have a absolute contraindication to the biosimilar for Actemra, Tyenne(tocilizumab-aazg)? <input type="checkbox"/> Yes <input type="checkbox"/> No Please submit documentation.</p>		
<p>For ankylosing spondylitis/ axial spondyloarthritis, also answer the following: Has the patient had an adequate trial and failure of at least TWO non-steroidal anti-inflammatory agents (NSAIDs)? <input type="checkbox"/> Yes <input type="checkbox"/> No (Provide NSAIDs and dates of service)</p> <p>Has the patient tried methotrexate? <input type="checkbox"/> Yes <input type="checkbox"/> No (Provide dates of service)</p> <p>Has the patient tried sulfasalazine? <input type="checkbox"/> Yes <input type="checkbox"/> No (Provide dates of service)</p>		

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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 following 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:

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 why 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

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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

Reauthorization:

If this is a reauthorization request, answer the following questions:

Does the patient have an active infection? Yes No

Select if Enbrel is prescribed by one of the following specialists:

- Dermatologist
- Rheumatologist

Will Enbrel be used in combination with another biologic or immunomodulatory agent (such as Kineret, Rituxan, Remicade, Orencia, Cimzia, Humira, Simponi, Actemra, or Xeljanz)? Yes No

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:** _____

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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