PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Enbrel® (etanercept)

Phone: 215-991-4300   Fax back to: 866-240-3712

HEALTH PARTNERS 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 print clearly.**

Patient Name:	**Physician Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic. Id:
Address:	Address:	
City, State, Zip:	City, State, Zip:	

Drug Name:

Expedited/Urgent

Directions:

Please answer the following questions and sign below:
Q1. What is the requested duration of therapy? 6 months or less   More than 6 months
Q2. What is the prescriber's specialty? Rheumatologist   Dermatologist   Other
Q3. If Other, please specify:
Q4. What is the patient's diagnosis? Moderate to severe active Rheumatoid Arthritis Psoriatic Arthritis Chronic moderate to severe Plaque Psoriasis Moderately to severely active Polyartricluar Juvenile Idiopathic Arthritis (greater than or equal to 2 years old) Active Ankylosing Spondylitis Other
Q5. If OTHER, please specify:
Q6. If the diagnosis is Rheumatoid Arthritis or Psoriatic Arthritis; Has the patient failed or had an inadequate response to the trial of at least one or more DMARD OR is intolerant to DMARDs. [e.g., Imuran® (azathioprine), Ridaura® (oral gold), Plaquenil® (hydroxychloroquine), Cuprimine® (D-penicillamine), Azulfidine® (sulfasalazine), methotrexate and NSAIDs]? Yes   No
Q7. For a diagnosis of Psoriasis, what is the percentage of surface area involvement? Less than 10% involvement Greater than 10% involvement
Q8. If greater than 10%; Has the patient failed or had an inadequate response to the trial of Methotrexate OR UVB therapy (alone or in combination with other medications) OR Soriatane (also requires prior authorization)?

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Yes No

Q9. If less than 10%, Has the patient failed or had an inadequate response to the trial of, Tar, 1 topical steroid (high to very high potency) and Dovonex or Anthralin?

Yes No

Q10. For moderately to severely active polyarticular-course juvenile rheumatoid arthritis; Has the patient failed or had an inadequate response to the trial of one or more DMARD or is intolerant to DMARDs. [e.g., NSAIDs, Azulfudine® (sulfasalazine), methotrexate, Imuran® (azathioprine), Ridaura® (oral gold), cyclosporine, prednisone]?

Yes No

Q11. For polyartricluar juvenile idiopathic arthritis: Is the patient equal to or greater than 2 years old?

Yes No

Q12. If the diagnosis is Ankylosing spondylitis: Has the patient failed or had an inadequate response to the trial of at least one or more DMARD's or is intolerant to DMARD's. [e.g., NSAID's, Azulfudine® (sulfasalazine), methotrexate]?

Yes No

Q13. Has the patient been evaluated for active or latent tuberculosis infection with a tuberculin skin test prior to the initiation of therapy?

Yes No

Q14. If latent infection is diagnosed, has appropriate prophylaxis in accordance with the CDC and prevention guidelines been instituted?

Yes No N/A

Q15. Deliver to:

Physician's Office Home Delivery

Q16. Delivery date needed:

Physician Signature **Date**

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