

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Enbrel® (etanercept)

**Complete form in its entirety and fax to:
 Prior Authorization of Benefits (PAB) Center at (866) 807- 6241**

1. PATIENT INFORMATION
2. PHYSICIAN INFORMATION

Patient Name: _____	Prescribing Physician: _____
Patient ID #: _____	Physician Address: _____
Patient DOB: _____	Physician Phone #: _____
Date of Rx: _____	Physician Fax #: _____
Patient Phone #: _____	Physician Specialty: _____
Patient Email Address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician Email Address: _____

3. MEDICATION
4. STRENGTH, QUANTITY, & APPROVAL DURATION REQUESTED:

<input type="checkbox"/> Enbrel (etanercept)	<input type="checkbox"/> 25mg <input type="checkbox"/> 8 injections per 28 days for LIFE (RA, Poly-Articular Juvenile Idiopathic Arthritis, Psoriatic Arthritis, or Ankylosing Spondylitis)
	<input type="checkbox"/> 50mg <input type="checkbox"/> 8 injections per 28 days for 12 WKS (Chronic Plaque Psoriasis – Initial Therapy)
	<input type="checkbox"/> 4 injections per 28 days for LIFE (Chronic Plaque Psoriasis – Continuation of Therapy)
	<input type="checkbox"/> 4 injections per 28 days for LIFE (RA, Poly-Articular Juvenile Idiopathic Arthritis, Psoriatic Arthritis, or Ankylosing Spondylitis)

5. DIAGNOSIS:
6. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY TO THE DIAGNOSIS

NOTE: Areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

A RESPONSE IS REQUIRED FOR EACH OF THE FOLLOWING:

- Yes No Patient has a latex allergy
- Yes No Patient has tuberculosis, or other active serious infections, or a history of recurrent infections
- Yes No Patient had a tuberculin skin test (TST), or a CDC-recommended equivalent, to rule out latent tuberculosis
- Yes No Patient has moderate to severe (NYHA Class III/IV) Congestive Heart Failure (CHF)
- Yes No Patient has Multiple Sclerosis or any other demyelinating neurologic disease
- Yes No Patient is currently receiving cyclophosphamide therapy, other TNF antagonists or anakinra (Kineret)
- Yes No Patient is concurrently being administered live vaccines
- Ankylosing Spondylitis:**
 - Yes No Patient is 18 years of age or older
 - Yes No Patient has failed, had inadequate response to, or is contraindicated for treatment w/sulfasalazine, methotrexate, or NSAIDs
- Chronic moderate to severe plaque psoriasis:**
 - Yes No Patient is 18 years of age or older
 - Yes No Patient's disease is controlled with topical therapy
 - Yes No Are the patient's symptoms moderate to severe?
What is the percent of BSA affected
 - Greater than 10% Less than 10%, sensitive areas (head, neck, palms, soles, genitalia)
 - Other: _____
- Yes No Patient has had a failure to achieve an adequate clinical response with, or medical contraindication to the use of phototherapy or other systemic therapies (e.g. methotrexate, acitretin, or cyclosporine)

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Patient Name: _____

Patient ID#: _____

Moderate to severely active Juvenile Idiopathic Arthritis (2 years of age and older):

Yes No Has the patient failed or had an inadequate response to 1 or more DMARDs?

If yes, what DMARD has the patient tried

- | | | |
|--|---|--|
| <input type="checkbox"/> Azulfidine (sulfasalazine) | <input type="checkbox"/> Methotrexate | <input type="checkbox"/> Cytoxin |
| <input type="checkbox"/> Cuprimine / Depen (penicillamine) | <input type="checkbox"/> Plaquenil (hydroxychloroquine) | <input type="checkbox"/> Cyclosporine (Neoral or Sandimmune) |
| <input type="checkbox"/> Imuran (azathioprine) | <input type="checkbox"/> Ridaura (auranofin) | <input type="checkbox"/> Minocycline (Minocin or Dynacin) |
| <input type="checkbox"/> Leflunomide (Arava) | <input type="checkbox"/> Gold Sodium Thiomalate (Myochrysine) | <input type="checkbox"/> Other: _____ |

Active Psoriatic Arthritis:

Yes No Patient is 18 years of age or older

Yes No Patient has active arthritis with at least 3 swollen and 3 tender joints

Yes No Patient presents plaque psoriasis with a qualifying target lesion at least 2cm in diameter

Areas of distribution involved

- | | |
|--|--|
| <input type="checkbox"/> Ankylosing Spondylitis-like Arthritis | <input type="checkbox"/> Asymmetric Arthritis |
| <input type="checkbox"/> Arthritis Mutilans | <input type="checkbox"/> Distal Interphalangeal Joint Involvement |
| | <input type="checkbox"/> Polyarticular Arthritis, w/o Rheumatoid Nodules |

Yes No Patient has a failure to achieve clinical response or has a medical contraindication to DMARD therapy, like methotrexate & sulfasalazine

If yes, what DMARD has the patient tried

- | | | |
|--|---|--|
| <input type="checkbox"/> Azulfidine (sulfasalazine) | <input type="checkbox"/> Methotrexate | <input type="checkbox"/> Cytoxin |
| <input type="checkbox"/> Cuprimine / Depen (penicillamine) | <input type="checkbox"/> Plaquenil (hydroxychloroquine) | <input type="checkbox"/> Cyclosporine (Neoral or Sandimmune) |
| <input type="checkbox"/> Imuran (azathioprine) | <input type="checkbox"/> Ridaura (auranofin) | <input type="checkbox"/> Minocycline (Minocin or Dynacin) |
| <input type="checkbox"/> Leflunomide (Arava) | <input type="checkbox"/> Gold Sodium Thiomalate (Myochrysine) | <input type="checkbox"/> Other: _____ |

Moderate to severely active Rheumatoid Arthritis:

Yes No Patient has failed or had an inadequate response to 1 or more DMARDs

If yes, what DMARD has the patient tried

- | | | |
|--|---|--|
| <input type="checkbox"/> Azulfidine (sulfasalazine) | <input type="checkbox"/> Methotrexate | <input type="checkbox"/> Cytoxin |
| <input type="checkbox"/> Cuprimine / Depen (penicillamine) | <input type="checkbox"/> Plaquenil (hydroxychloroquine) | <input type="checkbox"/> Cyclosporine (Neoral or Sandimmune) |
| <input type="checkbox"/> Imuran (azathioprine) | <input type="checkbox"/> Ridaura (auranofin) | <input type="checkbox"/> Minocycline (Minocin or Dynacin) |
| <input type="checkbox"/> Leflunomide (Arava) | <input type="checkbox"/> Gold Sodium Thiomalate (Myochrysine) | <input type="checkbox"/> Other: _____ |

Yes No Patient will be taking Enbrel in conjunction with methotrexate

7. PHYSICIAN SIGNATURE

Prescriber or Authorized Signature

Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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