EXPRESS SCRIPTS®

Prior Authorization Form
Enbrel

This form is based on Express Scripts standard criteria and may not be applicable to all patients; certain plans and situations may require additional information beyond what is specifically requested.
Additional forms available: www.express-scripts.com/pa

Fax completed form to **1-877-329-3760**
If this an **URGENT** request, please call 1-800-753-2851

Patient Information

Patient First Name: _____

Patient Last Name: _____

Patient ID#: _____

Patient DOB: _____

Patient Phone #: _____

Prescriber Information

Prescriber Name: _____

Prescriber DEA/NPI **(required)**: _____

Prescriber Phone #: _____

Prescriber Fax #: _____

Prescriber Address: _____

State: _____ Zip Code: _____

Primary Diagnosis: _____ ICD Code: _____

Please indicate which drug and strength is being requested:

☐ Enbrel 25mg/0.5ml Solution for Injection ☐ Enbrel 50mg/ml Solution for Injection ☐ Enbrel 25mg Powder for Injection

Directions for use (i.e. QD, BID, PRN & Qty): _____

Please complete the clinical assessment:		
1. Has the patient been established on Enbrel for greater than or equal to 90 days?	☐ Yes	☐ No

2. What is the indication or diagnosis?

- ☐ Rheumatoid arthritis in an adult
- ☐ Juvenile idiopathic arthritis (JIA or JRA)
- ☐ Plaque psoriasis
- ☐ Psoriatic arthritis
- ☐ Ankylosing spondylitis
- ☐ All other diagnoses (please indicate): _____

If all other diagnoses, please list <u>all</u> therapies and duration of therapy the patient has tried for their current diagnosis: _____

_____

_____