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 all therapies and duration of therapy the patient has tried for their current diagnosis: _____

_____

_____

3. Has the patient tried one DMARD (brand or generic; oral or injectable) for at least 3 months? If different duration other than 3 months, please specify: _____ ☐ Actemra ☐ Arava (leflunomide) ☐ Cimzia ☐ Humira ☐ Kineret ☐ Methotrexate [MTX] (oral, injection) ☐ Imuran (azothiaprine) ☐ 6-mercaptopurine ☐ leflunomide ☐ Orencia ☐ Plaquenil (hydroxychloroquine) ☐ Remicade ☐ Rituxan ☐ Simponi ☐ Sulfasalazine ☐ Other: _____ _____	☐ Yes	☐ No	☐ N/A
4. Is Humira to be given in combination with any of the following DMARDS: ☐ Actemra (tocilizumab) ☐ Cimzia (certolizumab pegol) ☐ Humira (adalimumab) ☐ Kineret (anakinra) ☐ Methotrexate [MTX] (oral, injection) ☐ Remicade (infliximab) ☐ Orencia (abatacept) ☐ Rituxan (rituximab) ☐ Simponi (golimumab) ☐ Stelara (ustekinumab) ☐ Xeljanz (tofacitinib) ☐ Other: _____			
6. Please list the prescriber or consulting prescriber's specialty: _____			
7. <u>If the diagnosis is Rheumatoid arthritis in an adult</u>, does the patient have early RA (defined as disease duration of less than 6 months) with at least one of the following features of poor prognosis: functional limitation (e.g., based on HAQ-DI score); extraarticular disease such as rheumatoid nodules, RA vasculitis, or Felty's syndrome; positive rheumatoid factor or anti-CCP antibodies; or bony erosions by radiograph?	☐ Yes	☐ No	☐ N/A
8. <u>If the diagnosis is Rheumatoid arthritis in an adult</u>, does the patient have a contraindication or intolerance to methotrexate and leflunomide, as determined by the prescribing physician?	☐ Yes	☐ No	☐ N/A
9. <u>If the diagnosis is plaque psoriasis</u> does the patient have a contraindication to one oral agent for psoriasis such as methotrexate, as determined by the prescribing physician?	☐ Yes	☐ No	☐ N/A
10. <u>If the diagnosis is plaque psoriasis</u> has the patient experienced an intolerance to a trial of at least one oral or biologic therapy for plaque psoriasis (e.g., methotrexate, cyclosporine, Soriatane, Humira, Remicade, or Stelara)?	☐ Yes	☐ No	☐ N/A
11. <u>If the diagnosis is plaque psoriasis</u>, has the patient tried a systemic therapy or phototherapy for 3 months with one of the following: If yes, please indicate: ☐ Soriatane (Acitretin) ☐ Humira (Adalimumab) ☐ Cyclosporine ☐ Remicade (Infliximab) ☐ Methotrexate ☐ Oral methoxsalen plus ultraviolet A light (PUVA) ☐ Stelara (Ustekinumab) ☐ Other: _____ _____	☐ Yes	☐ No	☐ N/A

12. If the diagnosis is juvenile idiopathic arthritis (JIA or JRA), does the patient have an absolute contraindication to methotrexate (eg, pregnancy, breast feeding, alcoholic liver disease, immunodeficiency syndrome, blood dyscrasias), sulfasalazine, or leflunomide?	☐ Yes	☐ No	☐ N/A
13. If the diagnosis is juvenile idiopathic arthritis (JIA or JRA), has the patient tried an NSAID?	☐ Yes	☐ No	☐ N/A
14. If the diagnosis is juvenile idiopathic arthritis (JIA or JRA), has the prescriber determined that the patient has aggressive disease?	☐ Yes	☐ No	☐ N/A

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

_____

_____

_____

Prescriber Signature: _____Date: _____

Office Contact Name: _____ Phone Number: _____

Based upon each patient's prescription plan, additional questions may be required to complete the prior authorization process. If you have any questions about the process or required information, please contact our prior authorization team at the number listed on the top of this form.

Prior Authorization of Benefits is not the practice of medicine or a substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for the patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

The document(s) accompanying this transmission may contain confidential health information. This information is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you received this information in error, please notify the sender immediately and arrange for the return or destruction of the documents.