Premier Health Plan
Pharmacy Services
Commercial Phone: 855-266-0713
Exchange Phone: 866-822-2413
Fax: 855-862-6518

ENBREL
Prior Authorization Form

□ Standard Request □ Expedited Request	If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. ***For state exchanges only:*** The above disclaimer applies for exigent circumstances. Expedited review may also be requested when you are undergoing a current course of treatment using a non-formulary drug.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested:	Strength:	Directions:	Quantity Dispensed:
Enbrel			
□ New medication □ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.	

Clinical Information

Disease Severity:
□ Mild
□ Moderate
□ Severe

PPD (tuberculin) test:
□ Positive
□ Negative
Date:_____

Is the member currently using another TNF-blocking or biologic agent in combination with Enbrel? □ Yes □ No
Medication:_____

Does the member currently have evidence of infection? □ Yes □ No

Please indicate the diagnosis on the left and complete the corresponding questions.

□ Rheumatoid Arthritis

OR

□ Juvenile Idiopathic Arthritis

Has the member tried and failed Methotrexate for at least 3 months? □ Yes □ No

Please indicate if the member tried and failed any of the following for at least *3 months*

Medication	Dates on Therapy	Dose	Reason for Discontinuing
□ Methotrexate			
□ Leflunomide (Arava)			
□ Sulfasalazine (Azulfidine)			
□ Minocycline (Minocin)			
□ Hydroxychlorquine (Plaquenil)			

□ Psoriatic Arthritis

Is the members disease dominant: □ Peripheral □ Axial
Has the member tried and failed any NSAIDs for at least 3 months? □ Yes □ No

Please indicate if the member tried and failed any of the following for at least *3 months*

Medication	Dates on Therapy	Dose	Reason for Discontinuing
□ NSAIDs			

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Member Name:	DOB:	Health Plan ID:
Please be sure to complete and include this page with the 1st page of this form.		

☐ Psoriatic Arthritis	☐Methotrexate			
	☐ Cyclosporine (Neoral, Sandimmune)			
	☐Sulfasalazine (Azulfidine)			
	☐ Leflunomide (Arava)			
☐ Ankylosing Spondylosis	Is the members disease dominant: ☐ Peripheral ☐ Axial Has the member tried and failed any NSAIDs for at least 3 months? ☐Yes ☐No			
	Please indicate if the member tried and failed any of the following for at least *3 months*			
	Medication	**Dates on Therapy**	**Dose**	**Reason for Discontinuing**
	☐Sulfasalazine (Azulfidine)			
	☐Methotrexate			
☐ Plaque Psoriasis	Has the member tried and failed any topical treatment? ☐Yes ☐No Does the member have psoriasis on the palms, soles, head, neck, or genitalia? ☐Yes ☐No Has the member tried and failed phototherapy or photochemotherapy? ☐Yes ☐No Please indicate body surface area (BSA) involvement: ☐Less than 10% ☐Greater than or equal to 10%			
	Please indicate if the member tried and failed any of the following for at least *3 months*?			
	Medication	**Dates on Therapy**	**Dose**	**Reason for Discontinuing**
	☐Topical:_____			
	☐Methotrexate			
	☐ Cyclosporine (Neoral, Sandimmune)			
	☐ Acitretin (Soriatane)			

Please provide any additional information which should be considered in the space below:

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