Premier Health Plan

Premier Health Plan
Pharmacy Services
Phone: 866-822-2714
Fax: 855-862-6518

ENBREL
Prior Authorization Form

□ Standard Request (72 hours) □ Expedited Request (24 hours)	If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For expedited requests you will receive a decision within 24 hours. You cannot request an expedited coverage determination if you are requesting reimbursement for a drug you already received.

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 with an inadeq response? □ Yes □ No

If no, please fill out chart with other drug trials

Please indicate if the member tried and failed any of the following

Medication	Dates on Therapy	Dose	Reason for Discontinuing
□ Leflunomide			
□ Sulfasalazine			
□ Hydroxychlorquine			

□ Psoriatic Arthritis

Is the members disease dominant: □ Peripheral □ Axial, skin, nail, enthesitis, dactylitis

Has the member tried and failed NSAIDs (trial of 1 required for peripheral disease and 2 for axial, nail, enthesitis, dactylitis)? □ Yes □ No

Please indicate if the member tried and failed any of the following

Medication	Dates on Therapy	Dose	Reason for Discontinuing
□ NSAIDs (please specify agent(s))			
□ Methotrexate			

☐ Psoriatic Arthritis	☐Cyclosporine			
	☐Sulfasalazine			
	☐ Leflunomide			
☐ Ankylosing Spondylosis	Is the members disease dominant: ☐ Peripheral ☐ Axial Has the member tried and failed at least 2 NSAIDs? ☐Yes ☐No			
	Please indicate any drug trials			
	Medication	**Dates on Therapy**	**Dose**	**Reason for Discontinuing**
☐ 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 5% ☐Greater than or equal to 5%			
	Please indicate if the member tried and failed any of the following			
	Medication	**Dates on Therapy**	**Dose**	**Reason for Discontinuing**
	☐Topical:_____			
	☐Methotrexate			
	☐ Cyclosporine			
	☐ Acitretin			

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