



**2023 PRIOR AUTHORIZATION REQUEST FORM**

Enbrel - Medicare

Phone: 215-991-4300

Fax back to: 866-371-3239

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.**

<b>Patient Name:</b>	<b>Prescriber Name:</b>	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: <input type="checkbox"/> Medicare	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	<b>Specialty/facility name (if applicable):</b>	

**REQUEST FOR EXPEDITED REVIEW:** By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

**Please attach any pertinent medical history including labs and information for this member that may support approval.  
Please answer the following questions and sign.**

Q1. Does the patient have the diagnosis of rheumatoid arthritis?

Yes  No

Q2. Is the patient 18 years of age or older?

Yes  No

Q3. Is there documentation of inadequate response, intolerance, or contraindication to at least one or more disease modifying antirheumatic drugs (DMARDs) (e.g., azathioprine, hydroxychloroquine, D-penicillamine, sulfasalazine, methotrexate and non-steroidal anti-inflammatory drugs [NSAIDs])?  
If YES, go to 15.

Yes  No

Q4. Does the patient have the diagnosis of plaque psoriasis?

Yes  No



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<p><b>Q5. Is the patient 4 years of age or older?</b></p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p><b>Q6. Is the disease moderate to severe?</b></p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p><b>Q7. Is there documentation of inadequate response, intolerance or contraindication to methotrexate OR ultraviolet-B (UVB) therapy (alone or in combination with other medications) OR acitretin (requires prior authorization)?</b></p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p><b>Q8. Is there documentation of inadequate response, intolerance or contraindication to one topical steroid (high to very high potency) AND calcipotriene 0.005% cream?</b></p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p><b>Q9. Does the patient have the diagnosis of polyarticular juvenile idiopathic arthritis (JIA) or psoriatic arthritis (PsA)?</b></p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p><b>Q10. Is the patient 2 years of age or older?</b></p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p><b>Q11. Is there documentation of inadequate response, intolerance, or contraindication to one or more disease modifying anti-rheumatic drug (DMARD) OR is intolerant to DMARDS (e.g., non-steroidal anti-inflammatory drugs [NSAIDs], sulfasalazine, methotrexate, azathioprine, cyclosporine, or prednisone)?</b></p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p><b>Q12. Does the patient have the diagnosis of ankylosing spondylitis?</b></p>



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<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q13. Is the patient 18 years of age or older?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q14. Is there documentation of inadequate response, intolerance or contraindication to at least two or more non-steroidal anti-inflammatory drugs (NSAIDs) OR is intolerant to NSAIDs?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q15. Is Enbrel being prescribed by or in consultation with a rheumatologist?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q16. Is Enbrel being prescribed by or in consultation with a dermatologist?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q17. Has the patient been evaluated for active or latent tuberculosis (TB) infection with a tuberculin skin test prior to the initiation of therapy?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q18. Was the tuberculin skin test negative?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q19. Has the patient received appropriate prophylaxis in accordance with Centers for Disease Control and Prevention (CDC) guidelines?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q20. Requested Duration:	
<input type="checkbox"/> 12 months	<input type="checkbox"/> Other

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Patient Name:	Prescriber Name:
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Q21. Additional Information:

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

2023 Medicare Prior Authorization Request