



Please Note: Medical Necessity Prior Authorization may be overridden for both formulary coverage and benefit design restrictions. They are issued at the full discretion of the benefit manager.

## PRIOR AUTHORIZATION **BYPASS** **Enbrel® (etanercept)**

Bypass the Prior Authorization by Modifying the following Prescription Forms to the Patient's needs

Name \_\_\_\_\_  
 Address \_\_\_\_\_

**Rx** *Refer for RA/  
 Psoriasis  
 Protocol if adult  
 (18 years of age  
 or older)*

MD \_\_\_\_\_  
 Signature \_\_\_\_\_

Name \_\_\_\_\_  
 Address \_\_\_\_\_

**Rx** naltrexone 1% topical  
 quantity # 60gm  
 sig: itching

as directed by physician

Dx: PSORIASIS  
 ICD 10: L 40.9

MD \_\_\_\_\_  
 Signature \_\_\_\_\_

# SAMPLE



**Prescriber Information**

<b>Last Name:</b> <input type="text"/> <b>DEA/NPI:</b> <input type="text"/> <b>Phone</b> <input type="text"/>	<b>First Name</b> <input type="text"/> <b>Specialty:</b> <input type="text"/> <b>Fax</b> <input type="text"/>
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**Member Information**

<b>Last Name:</b> <input type="text"/> <b>Member ID Number</b> <input type="text"/>	<b>First Name</b> <input type="text"/> <b>DOB:</b> <input type="text"/>
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**Medication Information:**

<b>Drug Name and Strength:</b> <input type="text"/> <b>Diagnosis:</b> <input type="text"/>	<b>Quantity and Dosing:</b> <input type="text"/> <b>Duration:</b> <input type="text"/>
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When advised below, please include all requested fax documentation (lab results, etc.) when submitting this Prior Authorization fax form; not submitting requested documentation could delay the clinical review process.

**Enbrel (etanercept) Prior Authorization Form**

Initial Therapy		
You must answer ALL of the following questions		
1. Does the patient have an active infection?	Y	N
2. Will Enbrel be used in combination with another TNF antagonist or biologic (such as Kineret, Rituxan, Remicade, Orencia, Cimzia, Humira, Simponi, Actemra or Xeljanz)?	Y	N
3. What is the patient's diagnosis? <b>(Please circle.)</b> <ul style="list-style-type: none"> <li>• Rheumatoid arthritis</li> <li>• Juvenile idiopathic arthritis</li> <li>• Psoriatic arthritis</li> <li>• Ankylosing spondylitis</li> <li>• Plaque psoriasis</li> <li>• Other: _____</li> </ul>		
RHEUMATOID ARTHRITIS		
4. Is the patient 18 years of age or older?	Y	N
5. Is the medication prescribed by a rheumatologist?	Y	N
6. Has the patient tried and had an inadequate response or intolerance to triple therapy with methotrexate (or another oral disease modifying anti-rheumatic agent (DMARD) such as Imuran, Ridaura, Cuprimine, Arava), PLUS sulfasalazine (Azulfidine), PLUS hydroxychloroquine?	Y	N
7. Is the patient unable to take a non-biologic DMARD due to chronic liver disease (such as chronic hepatitis, fatty liver, nonalcoholic steatohepatitis/NASH, or elevated liver enzymes)?	Y	N



**JUVENILE IDIOPATHIC ARTHRITIS OR PSORIATIC ARTHRITIS**

4. Is the medication prescribed by a rheumatologist?	Y	N
5. Is the medication prescribed by a dermatologist?	Y	N
6. Is the patient 2 years of age or older?	Y	N
7. Has the patient had a trial and inadequate response or intolerance to an oral disease modifying anti-rheumatic agent (e.g., methotrexate, azathioprine (Imuran), auranofin (Ridaura), hydroxychloroquine (Plaquenil), penicillamine (Cuprimine), sulfasalazine (Azulfidine), or leflunomide (Arava)?	Y	N
8. Is the patient unable to take a non-biologic DMARD due to chronic liver disease (such as chronic hepatitis, fatty liver, nonalcoholic steatohepatitis/NASH, or elevated liver enzymes)? If no, please provide rationale explaining why the patient cannot take the prerequisite DMARDs _____	Y	N

**ANKYLOSING SPONDYLITIS**

4. Is the patient 18 years of age or older?	Y	N
5. Is the medication prescribed by a rheumatologist?	Y	N
6. Has the patient tried and had an inadequate response, intolerance, or contraindication to at least TWO non-steroidal anti-inflammatory agents (NSAIDs)?	Y	N

**PLAQUE PSORIASIS**

4. Is the patient 18 years of age or older?	Y	N
5. Is the medication prescribed by a dermatologist?	Y	N
6. Does the patient have plaques covering 3 percent or more of the body surface area (BSA) OR less than 3 percent of BSA with involvement of palms, soles, head and neck, or genitalia which causes disruption of normal activities?	Y	N
7. Has the patient tried and had an inadequate response or intolerance to at least one of the following therapies: methotrexate, cyclosporine, and/or phototherapy? If no, please provide rationale explaining why the patient cannot take the prerequisite agents _____	Y	N

**Renewal Therapy**

**You must answer ALL of the following questions**

1. Does the patient have an active infection?	Y	N
2. Will Enbrel be used in combination with another TNF antagonist or biologic (such as Kineret, Rituxan, Remicade, Orencia, Cimzia, Humira, Simponi, Actemra or Xeljanz)?	Y	N
3. Is the patient continuing to have a positive clinical response and remission of disease is maintained with Enbrel therapy? <i>Please provide documentation (e.g. chart notes) supporting a positive clinical response.</i>	Y	N
4. What is the patient's diagnosis? <b>(Please circle.)</b> <ul style="list-style-type: none"> <li>• Rheumatoid arthritis</li> <li>• Juvenile idiopathic arthritis</li> <li>• Psoriatic arthritis</li> <li>• Ankylosing spondylitis</li> <li>• Plaque psoriasis</li> <li>• Other: _____</li> </ul>		
5. Is the medication prescribed by a rheumatologist?	Y	N
6. Is the medication prescribed by a dermatologist?	Y	N

**Please note, not all drugs/diagnoses are covered on all plans.**



Comments: \_\_\_\_\_  
*Information given on this form is accurate as of this date.*

*Prior Authorization forms are located on the Cover Page. Print a new form for each request as forms are updated periodically.*

\_\_\_\_\_  
**Prescriber or Authorized Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Authorized Medical Staff – Name/Title**

**Attention Healthcare Provider: If you would like to discuss this request with a medical professional, please contact the Prior Authorization Department whose numbers appear on the Cover Page.**

**I understand that USDoctor’s use or disclosure of individually identifiable health information, whether furnished by me or obtained by another source such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).**



**Contact Information:**

Telephone: (855)251.9116

Fax: (248)593.9575

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**PRIOR AUTHORIZATION FORM:  
COVER PAGE**

MEMBER INFORMATION			
First Name		Last Name	
Plan			
Member ID		Date of Birth	
DRUG INFORMATION			
Drug Name			
Quantity		ICD-10	
Directions		Duration of Therapy	
Diagnosis			
PLEASE LIST ALTERNATIVE THERAPIES THAT HAVE BEEN ATTEMPTED AND ANY OTHER PERTINENT INFORMATION RELATED TO DRUG AND/OR DISEASE STATE. IF NOT PRESENT, WITHIN NORMAL LIMITS WILL BE USED FOR THE REVIEW.			
<b>Medication/Failure Reason:</b>			
IgE: _____ ESR: _____ CRP: _____ # Joints: _____ %BSA: _____ Height: _____ Weight: _____ BMI: _____ HA1C: _____ Hemoglobin: _____ Hematocrit: _____ T-Score: _____ Dialysis: _____ Long Term Care Facility: _____ Self Injecting: _____ Stimulation test: _____ / _____ Growth velocity: _____ #Chemotherapy cycles/month: _____ Mini-Mental Status Test: _____ Baseline Free testosterone/Total testosterone: _____ / _____ HCV RNA viral load: _____ Viral Genotype: _____ ALT: _____			
PHYSICIAN INFORMATION			
Physician Signature		Date	
Physician Name		NPI #	
Phone Number		Fax Number	
Action Needed	Only mark Urgent when standard review time would seriously harm the member's life or health or ability to regain maximum function  <input type="checkbox"/> Urgent <input type="checkbox"/> For Review	Pharmacy Fax	
The information contained in this facsimile message, including the attachments, may be privileged, may constitute inside information and is intended only for use of the addressee. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited and may be unlawful. If you have received this communication in error, please immediately notify me by replying to this message and destroy the original message.			