HEALTHTRANS

Prior Authorization Request

Date of Request _____

Enbrel

Enbrel (Etanercept) is a tumor necrosis factor antagonist used for rheumatoid arthritis, spondyloarthritis, and psoriatric arthritis in patients ≥ 18 years of age. Indications

-moderate to severe rheumatoid arthritis,

-juvenile rheumatoid arthritis,

-psoriatric arthritis or spondyloarthritis,

-ankylosing spondylitis or spondyloathropathy,

Patient must have failed (or intolerant to) adequate trial with methotrexate, have a negative latent tuberculosis test, and not use in conjunction with Kineret or Orencia. [3 months]

For reevaluation- symptomatic improvement as indicated by two of the following: reduction in ESR or C-reactive protein level, improvement in functional status, improvement in radiographic examination of involved joints, or reduction in duration of morning stiffness or fatigue. [12 months]

OR chronic (≥ 12 months) moderate to severe plaque psoriasis.

Patient must have chronic plaque psoriasis covering ≥ 10% of body surface area or less than 10% on face, hands, or feet with pain, bleeding or severe itching. Patient must have failed (or intolerant to) systemic therapy (methotrexate, cyclosporin, acitretin) or phototherapy (PUVA, UVB), and have a negative latent tuberculosis test. [12 weeks]

For reevaluation-patient shows clinical benefit. [12 months]

Member Information

Name _____

Enrollment / Cardholder ID _____

Group / Plan _____

Birth date _____

Address: _____

City State Zip _____

Relationship (Circle)

Subscriber Spouse Dependent

Gender (Circle)

Male Female

AGE: _____ **Weight (kg):** _____

Practitioner Information

Name _____

Agent / Contact Name _____

Specialty _____

Office / Clinic Name _____

Address _____

City State Zip _____

Phone ( ) -

Fax ( ) -

ID Number _____

Email @

Previous use? Y N

Negative latent TB test? Y N

Using with Kineret or Orencia? Y N

Requested Drug / Pharmaceutical

Enbrel (Etanercept)

Strength / Dose

Therapy Start Date

Condition / Diagnosis Related - Reason for Request

Duration of Therapy (Expected)

Type of Request (Circle)

One-Time On-Going

Clinical Drug / Lab History Pertinent to Request

Labs: **Baseline / Ongoing**

Formulary Alternative(s) Attempted YES NO (Circle)

Please List:

Contact Pharmacy? Y N

Pharmacy Phone Number

_____

Practitioner Signature

Date Received:
Reviewed By:
Forwarded To:

FAX Form to:
877-800-5633

HT Clinical Services Phone
866-805-1690